



Summary of Benefits

CareSource Advantage



H6178_OHMSNP363

CMS Approved 11/24/2009
Printed on 11/30/2009



CareSource Advantage (HMO)
2010 Summary of Benefits

For Contract H6178, Plan 001

Section I

Introduction to the Summary of Benefits Report For CARESOURCE ADVANTAGE (HMO) January 1, 2010 – December 31, 2010 17 Counties in the Most Populated Areas of Ohio

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

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

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

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

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

YOU HAVE CHOICES IN YOUR HEALTH CARE

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

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

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

HOW CAN I COMPARE MY OPTIONS?

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

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

WHERE IS CARESOURCE ADVANTAGE (HMO) AVAILABLE?

The service area for this plan includes: Butler, Cuyahoga, Delaware, Franklin, Greene, Hamilton, Lorain, Lucas, Madison, Mahoning, Medina, Montgomery, Stark, Summit, Trumbull, Warren, and Wood counties, OH. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN CARESOURCE ADVANTAGE (HMO)?

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

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

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

CAN I CHOOSE MY DOCTORS?

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

You can ask for a current Provider Directory or for an up-to-date list visit us at www.caresource.com. Our customer service number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither CareSource Advantage (HMO) nor the Original Medicare Plan will pay for these services.

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

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

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

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

CareSource Advantage (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.caresource.com.

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

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

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

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of CareSource Advantage (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Ohio KePRO, 1-800-589-7337.

As a member of CareSource Advantage (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Ohio KePRO, 1-800-589-7337.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

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

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

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

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

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-708-8729 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-750-0750 or 711.

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

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

- Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern
- Current and Prospective members should call toll-free (800) 708-8729 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD (800) 750-0750 or 711).
- Current and Prospective members should call locally (800) 708-8729 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD (800) 750-0750 or 711).
- For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.
- If you have special needs, this document may be available in other formats.

Section II

Summary of Benefits Report

(For Contract H6178, Plan 001)

Benefit Category	Original Medicare	CareSource Advantage (HMO)
Important Information		
<p>1 – Premium and other important information</p>	<p>The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><i>General</i> \$0 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p><i>In-Network</i> In 2010 the yearly Part B deductible amount is \$0. * Contact the plan for services that apply.</p>

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>2 – Doctor and hospital choice</p> <p>(For more information, see Emergency - #15 and Urgently needed care - #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><i>In-Network</i> You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p><i>Out-of-Network</i> Plan covers you when you travel in the U.S.</p>

Inpatient Care

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>3 – Inpatient hospital care</p> <p>(includes substance abuse and rehabilitation services)</p>	<p>In 2010 the amounts for each benefit period, \$0 or: Days 1 - 60: \$1,100 deductible* Days 61 - 90: \$275 per day* Days 91 - 150: \$550 per lifetime reserve day*</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p><i>In-Network</i> In 2010 the amounts for each benefit period: Days 1 - 60: \$0 deductible* Days 61 - 90: \$0 per day* Days 91 - 150: \$0 per lifetime reserve day*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers 90 days each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>4 – Inpatient mental health care</p>	<p>Same deductible and copay as inpatient hospital care (See “Inpatient hospital care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><i>In-Network</i> Same deductible and copay as inpatient hospital care (See “Inpatient hospital care”).</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>5 – Skilled nursing facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day* Days 21 - 100: \$137.50 per day*</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day* Days 21 - 100: \$0 per day*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>3-day prior hospital stay is required.</p>
<p>6 – Home health care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> \$0 copay for Medicare-covered home health visits.*</p>

Benefit Category	Original Medicare	CareSource Advantage (HMO)
7 - Hospice	<p>You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p><i>General</i> You must get care from a Medicare-certified hospice.</p>

Outpatient Care

Benefit Category	Original Medicare	CareSource Advantage (HMO)
8 – Doctor office visits	0% or 20% coinsurance	<p><i>General</i> See “Physical Exams,” for more information.</p> <p>Authorization rules may apply.</p> <p><i>In-Network</i> \$0 copay for each primary care doctor visit for Medicare-covered benefits.*</p> <p>0% of the cost for each in-area, network urgent care Medicare-covered visit.*</p> <p>0% of the cost for each specialist visit for Medicare-covered benefits.*</p>
9 – Chiropractic services	<p>Routine care not covered</p> <p>0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> 0% of the cost for each Medicare-covered visit.*</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>

Benefit Category	Original Medicare	CareSource Advantage (HMO)
10 – Podiatry services	Routine care not covered. 0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<i>General</i> Authorization rules may apply. <i>In-Network</i> 0% of the cost for each Medicare-covered visit.* Medicare-covered podiatry benefits are for medically-necessary foot care.
11 – Outpatient mental health care	0% or 45% coinsurance for most outpatient mental health services.	<i>General</i> Authorization rules may apply. <i>In-Network</i> 0% of the cost for each Medicare-covered individual or group therapy visit.*
12 – Outpatient substance abuse care	0% or 20% coinsurance	<i>General</i> Authorization rules may apply. <i>In-Network</i> 0% of the cost for Medicare-covered individual or group visits.*
13 – Outpatient services/surgery	0% or 20% coinsurance for the doctor 0% or 20% of outpatient facility charges	<i>General</i> Authorization rules may apply. <i>In-Network</i> 0% of the cost for each Medicare-covered ambulatory surgical center visit.* 0% of the cost for each Medicare-covered outpatient hospital facility visit.*
14 – Ambulance services (medically necessary ambulance services)	0% or 20% coinsurance	<i>General</i> Authorization rules may apply. <i>In-Network</i> 0% of the cost for Medicare-covered ambulance benefits.*

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>15 – Emergency care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% or 20% coinsurance for the doctor</p> <p>0% or 20% of facility charge</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><i>General</i></p> <p>0% of the cost for Medicare-covered emergency room visits.*</p> <p>This amount applies toward your in and out-of-network plan deductible.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the emergency room visit.</p>
<p>16 – Urgently needed care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% or 20% coinsurance</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><i>General</i></p> <p>0% of the cost for Medicare-covered urgently needed care visits.*</p>
<p>17 – Outpatient rehabilitation services</p> <p>(Occupational therapy, physical therapy, speech and language therapy)</p>	<p>0% or 20% coinsurance</p>	<p><i>General</i></p> <p>Authorization rules may apply.</p> <p><i>In-Network</i></p> <p>0% of the cost for Medicare-covered Occupational Therapy visits.*</p> <p>0% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.*</p>

Outpatient Medical Services and Supplies

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>18 – Durable medical equipment (includes wheelchairs, oxygen, etc.)</p>	<p>0% or 20% coinsurance</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> 0% of the cost for Medicare-covered items.*</p>
<p>19 – Prosthetic devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>0% or 20% coinsurance</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> 0% of the cost for Medicare-covered items.*</p>
<p>20 – Diabetes self-monitoring training, nutrition therapy, and supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% or 20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><i>In-Network</i> 0% of the cost for Diabetes self-monitoring training.*</p> <p>0% of the cost for nutrition therapy for Diabetes.*</p> <p>0% of the cost for Diabetes supplies.*</p>
<p>21 – Diagnostic tests, X-rays, lab services, and radiology services</p>	<p>0% or 20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.</p>	<p><i>General</i> Authorization rules may apply.</p> <p><i>In-Network</i> 0% of the cost for Medicare-covered lab services.*</p> <p>0% of the cost for Medicare-covered diagnostic procedures and tests.*</p> <p>0% of the cost for Medicare-covered X-rays.*</p> <p>0% of the cost for Medicare-covered diagnostic radiology services.*</p>

	Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	0% of the cost for Medicare-covered therapeutic radiology services.*
--	---	--

Preventive Services

Benefit Category	Original Medicare	CareSource Advantage (HMO)
22 – Bone mass measurement (for people with Medicare who are at risk)	0% or 20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<i>In-Network</i> 0% of the cost for Medicare-covered bone mass measurement.*
23 – Colorectal screening exams (for people with Medicare age 50 and older)	0% or 20% coinsurance Covered when you are high risk or when you are age 50 and older.	<i>In-Network</i> 0% of the cost for Medicare-covered colorectal screenings.*
24 – Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, pneumonia vaccine)	\$0 copay for flu and pneumonia vaccines 0% or 20% coinsurance for Hepatitis B vaccine You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.	<i>In-Network</i> \$0 copay for flu and pneumonia vaccines. No referral needed for flu and pneumonia vaccines. 0% of the cost for Hepatitis B vaccine.*
25 – Mammograms (annual screening) (for women with Medicare age 40 and older)	0% or 20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<i>In-Network</i> 0% of the cost for Medicare-covered screening mammograms.*

Benefit Category	Original Medicare	CareSource Advantage (HMO)
<p>26 – Pap smears and pelvic exams</p> <p>(for women with Medicare)</p>	<p>\$0 copay for pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>0% or 20% coinsurance for pelvic exams</p>	<p><i>In-Network</i></p> <p>0% of the cost for Medicare-covered pap smears.*</p> <p>0% of the cost for Medicare-covered pelvic exams.*</p>
<p>27 – Prostate cancer screening exams</p> <p>(for men with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance for the digital rectal exam</p> <p>\$0 for the PSA test; 0% or 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><i>In-Network</i></p> <p>0% of the cost for Medicare-covered prostate cancer screening.*</p>
<p>28 – End-Stage Renal Disease</p>	<p>0% or 20% coinsurance for renal dialysis</p> <p>0% or 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><i>In-Network</i></p> <p>0% of the cost for renal dialysis*</p> <p>0% of the cost for Nutrition Therapy for End-Stage Renal Disease.*</p>
<p>29 – Prescription drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug</p>	<p>Drugs covered under Medicare Part B</p> <p><i>General</i></p> <p>\$0 yearly deductible for Part B-covered drugs.*</p>

	<p>Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>0% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*</p>
		<p>Drugs covered under Medicare Part D <i>General</i> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.caresource.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from CareSource Advantage (HMO) for certain drugs.</p>

		<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and CareSource Advantage (HMO) approves the exception, you will pay Tier 4 cost sharing for that drug.</p> <p><i>In-Network</i> You pay a \$0 yearly deductible.</p> <p>You pay a \$0 copay for generic drugs until you have a total drug spend equaling \$2830. Then, the applicable copay applies.</p> <p><i>Initial Coverage</i> Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$1.10 copay; or - A \$2.50 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$3.30 copay; or - A \$6.30 copay. <p><i>Catastrophic Coverage</i> After your yearly out-of-pocket drug</p>
--	--	---

		<p>costs reach \$4,550, you pay a \$0 copay.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from CareSource Advantage (HMO).</p> <p>Out-of-Network Initial Coverage Depending on your income and institutional status, you will be reimbursed by CareSource Advantage (HMO) up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$1.10 copay; or - A \$2.50 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$3.30 copay; or - A \$6.30 copay. <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.</p>
30 – Dental services	Preventive dental services (such as cleaning) not covered.	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p>

		0% of the cost for Medicare-covered dental benefits.*
31 – Hearing services	<p>Routine hearing exams and hearing aids not covered.</p> <p>0% or 20% coinsurance for diagnostic hearing exams.</p>	<p><i>In-Network</i> \$0 copay for up to 1 hearing aid(s) every two years.</p> <p>0% of the cost for Medicare-covered diagnostic hearing exams*</p> <p>\$500 limit for hearing aids every two years.</p>
32 – Vision services	<p>0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><i>In-Network</i> \$0 copay for:</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery* - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of lenses every two years - up to 1 frame(s) every two years <p>0% of the cost for exams to diagnose and treat diseases and conditions of the eye.*</p> <p>\$100 limit for eye wear every two years.</p>
33 – Physical exams	<p>0% or 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><i>In-Network</i> \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>0% of the cost for Medicare-covered benefits*</p>

Benefit Category	Original Medicare	CareSource Advantage (HMO)
Health/Wellness education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<i>In-Network</i> The plan covers the following health/wellness education benefits: - nurse advice line \$0 copay for each Medicare-covered smoking cessation counseling session.*
Transportation (routine)	Not covered.	<i>In-Network</i> \$0 copay for up to 30 round trip(s) to plan-approved location every year.
Acupuncture	Not covered.	<i>In-Network</i> This plan does not cover acupuncture.
Emergency medical response system	Not covered.	<i>General</i> Authorization rules apply. <i>In-Network</i> \$0 copay for the Emergency Medical Response System. CareSource Advantage (HMO) members enrolled in case management may qualify for a personal emergency medical response device/system. This benefit requires prior authorization.
Visitor/Travel program	Not covered.	<i>General</i> When you travel outside of the CareSource Advantage (HMO) service area, special conditions apply. The CareSource Advantage (HMO) visitor/travel program includes a full range of medical

		services covered at up to \$5,000 per year. Prior authorization is required. (For more information, see #15 Emergency and #16 Urgently needed care.)
--	--	--

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

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

Medicaid is usually the payer of last resort – this means, as a member of our plan, you must access benefits that are covered by both programs through Medicare (CareSource Advantage (HMO)) first and Medicaid (ODJFS) last. Once you have reached your limit for a service in the Medicare program, you might be able to continue getting the benefit through the Medicaid program. In some cases, Medicaid will pay for services or costs that Medicare does not (such as routine dental and vision care, and hearing aids).

- If you have questions about how your benefits are coordinated between programs, contact -
- Medicare-CareSource Advantage (HMO) Member Services at 1-800-708-8729, Monday – Friday 8 a.m. – 8 p.m.
 - Medicaid-ODJFS Consumer Hotline toll-free at 1-800-324-8680 or TTY for the hearing impaired 1-800-292-3572, Monday – Friday 7a.m. – 8 p.m. and Saturday 8 a.m. – 5 p.m.

This information is a summary of the information provided in your ODJFS Medicaid Consumer Guide. For more detailed information, please refer to your Consumer Guide.

Medicaid Covered Services Through ODJFS *Ohio's Fee-For-Service Medicaid Program*

Hospital Services

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

Home Health Care and Long-Term Care

Benefit Category	Medicaid	Member Cost
Home Health Care	Part-time daily living care in your home. Nursing services and skilled therapies available when medically necessary and ordered by your doctor.	\$0 copay for Medicaid-covered services.
Long-Term Home and Community Care Options or "Waiver Services"	If you need long-term care but want to stay in your home, you may be able to do so through one of the home and community-based services waiver programs.	\$0 copay for Medicaid-covered services.
Care in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR)	These services are available to those who need long-term care in an institution.	Your Medicaid caseworker will determine a Patient Liability amount based on your income excluding certain deductions.
Hospice	Hospice is available to Medicaid consumers with a life expectancy of six months or less. Hospice helps meet the needs of the patient and family during the final stages of illness and dying.	\$0 copay for Medicaid-covered services.

Services at Your Health Care Provider's Office

Benefit Category	Medicaid	Member Cost
Doctor Office Visits	Up to 24 visits per year. You can get more if medically necessary.	\$0 copay for Medicaid-covered services.
Lab Testing and X-Rays	Covered when medically necessary and ordered by your doctor.	
Family Planning Visits and Services	As needed.	
Physical Exam Required for Job Placement	Exam is covered if not offered free of charge by employer.	
Prostate (Cancer) Tests	For men, once a year starting at age 50.	
Pap Smears and Pelvic Exams	Once a year for women ages 16 and older and sexually active adolescents.	

Mammography	For women starting at age 35.	
Speech Therapy	As medically necessary.	
Physical Therapy	Up to 30 visits each year.	
Occupational Therapy	Covered in a hospital setting only.	
Chiropractic Services	Covered for adults and children.	
Hearing Services	Covered for adults and children.	

Dental, Vision, and Dermatology

Benefit Category	Medicaid	Member Cost
Dental Check-Ups and Cleaning	Once every 6 months (180 days).	\$3 per dental visit.
Extractions and Fillings	As needed.	
Dentures and Partial Plates	Must be prior authorized. They may be replaced every 8 years.	
Braces	Must be prior authorized.	
Regular Eye Exams	If you are 21-59 years old: once every 24 months. If you are 20 years old or younger, or 60 years old or older: once every 12 months.	\$2 per routine exam.
Eye Glasses	If you are 21-59 years old: one pair every 24 months. If you are 20 years old or younger, or 60 years old or older: one pair every 12 months.	\$1 per eye glass fitting.
Contact Lenses, Tinted Lenses, Prosthetic Eye, and Low-Vision Aids	These items must be prior authorized and be medically necessary.	\$0 copay for Medicaid-covered services.
Dermatology (Skin) Services	Must be medically necessary and related to a disease or condition.	\$0 copay for Medicaid-covered services.

Prescription Medicine – Medicaid Covered Drugs

Benefit Category	Medicaid	Member Cost
Prescription Drugs	Medicaid covers over 25,000 prescription drugs from nearly 300 different categories. In some cases, prior authorization is	\$0 copay for Medicaid covered services.

	needed when a drug is prescribed and a less costly alternative is available.	
--	--	--

Pregnancy and Hospital Services

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

Transportation Services

Benefit Category	Medicaid	Member Cost
Transportation	<p>If you do not have a way to get to an appointment for health care services that are paid by Medicaid, call your county department of Job & family services for help.</p> <p>If you have a disability you may be able to use an ambulance or ambulette.</p>	\$0 copay for Medicaid-covered services.

