CareSource Advantage®
Zero Premium (HMO)

Annual Notice of Change for 2020
CareSource Advantage® Zero Premium (HMO) offered by CareSource

Annual Notice of Changes for 2020

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

- You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

What to do now

1. **ASK:** Which changes apply to you
   - Check the changes to our benefits and costs to see if they affect you.
     - It’s important to review your coverage now to make sure it will meet your needs next year.
     - Do the changes affect the services you use?
     - Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.
   - Check the changes in the booklet to our prescription drug coverage to see if they affect you.
     - Will your drugs be covered?
     - Are your drugs in a different tier, with different cost sharing?
     - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
     - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
     - Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
     - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.
Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider & Pharmacy Directory*.

Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

- Check coverage and costs of plans in your area.
  
  
  - Review the list in the back of your Medicare & You handbook.
  
  - Look in Section 3.2 to learn more about your choices.

- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you want to **keep** CareSource Advantage Zero Premium, you don’t need to do anything. You will stay in CareSource Advantage Zero Premium.

- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019**

- If you don’t join another plan by **December 7, 2019**, you will stay in CareSource Advantage Zero Premium.

- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

**Additional Resources**

- Please contact our Member Services number at 1-844-607-2827 for additional information. (TTY users should call 1-800-750-0750 or 711). Hours are October 1 – March 31: 8 a.m. – 8 p.m., Monday through Sunday; April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday.
To receive material in alternate formats such as large print, please contact Member Services at 1-844-607-2827 (TTY users should call 1-800-750-0750 or 711).

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About CareSource Advantage Zero Premium
• CareSource Advantage Zero Premium is an HMO plan with a Medicare contract. Enrollment in CareSource Advantage Zero Premium depends on contract renewal.
• When this booklet says “we,” “us,” or “our,” it means CareSource. When it says “plan” or “our plan,” it means CareSource Advantage Zero Premium.
• This information is not a complete description of benefits. Call 1-844-607-2827 for additional information. (TTY users should call 1-800-750-0750 or 711).
The table below compares the 2019 costs and 2020 costs for CareSource Advantage Zero Premium in several important areas. Please note this is only a summary of changes. A copy of the Evidence of Coverage is located on our website at CareSource.com/Medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$6,700</td>
<td>$6,700</td>
</tr>
<tr>
<td>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $9 per visit</td>
<td></td>
<td>Primary care visits: $10 per visit</td>
</tr>
<tr>
<td>Specialist visits: $50 per visit</td>
<td></td>
<td>Specialist visits: $50 per visit</td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td>$350 copay per day for days 1 through 5</td>
<td>$350 copay per day for days 1 through 5</td>
</tr>
<tr>
<td>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</td>
<td>$0 copay per day for days 6 through 90</td>
<td>$0 copay per day for days 6 through 90</td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Deductible: $250</td>
<td>Deductible: $150</td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td>Copayment/Coinsurance during the Initial Coverage Stage:</td>
<td>Copayment/Coinsurance during the Initial Coverage Stage:</td>
</tr>
<tr>
<td>Drug Tier 1: $6.00</td>
<td>Drug Tier 1: $5.00</td>
<td></td>
</tr>
<tr>
<td>Drug Tier 2: $15.00</td>
<td>Drug Tier 2: $15.00</td>
<td></td>
</tr>
</tbody>
</table>
### CareSource Advantage Zero Premium Annual Notice of Changes for 2020

#### Part D prescription drug coverage (continued)

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 3: $47.00</td>
<td></td>
<td>Drug Tier 3: $45.00</td>
</tr>
<tr>
<td>• Drug Tier 4: $100.00</td>
<td></td>
<td>Drug Tier 4: $100.00</td>
</tr>
<tr>
<td>• Drug Tier 5: 28%</td>
<td></td>
<td>Drug Tier 5: 30%</td>
</tr>
</tbody>
</table>
### Annual Notice of Changes for 2020
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

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

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

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$6,700</td>
<td>$6,700</td>
</tr>
<tr>
<td>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider & Pharmacy Directory* is located on our website at CareSource.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a *Provider & Pharmacy*
Directory. Please review the 2020 Provider & Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Provider & Pharmacy Directory is located on our website at CareSource.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. Please review the 2020 Provider & Pharmacy Directory to see which pharmacies are in our network.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2020 Evidence of Coverage.
<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and wellness education programs</td>
<td>Non-Medicare covered health and wellness education programs are not covered.</td>
<td>$0 copay for non-Medicare covered health and wellness education programs</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>Non-Medicare covered home-delivered meals are not covered</td>
<td>$0 copay for non-Medicare covered home-delivered meals. Limit of 2 meals a day for up to 14 days post discharge</td>
</tr>
<tr>
<td>Opioid treatment program services</td>
<td>Opioid treatment program services are not covered.</td>
<td>$50 copay for opioid treatment program services</td>
</tr>
<tr>
<td>Outpatient diagnostic tests and therapeutic services and supplies</td>
<td>$30 copay maximum for multiple lab and diagnostic tests at the same facility on the same day</td>
<td>$35 copay maximum for multiple lab and diagnostic tests at the same facility on the same day</td>
</tr>
<tr>
<td>Outpatient hospital services - surgery</td>
<td>You pay 20% coinsurance of the total cost of outpatient hospital surgery</td>
<td>You pay a $295 copay for outpatient hospital surgery</td>
</tr>
<tr>
<td>Outpatient mental health care</td>
<td>20% coinsurance for psychiatric services (group and individual)</td>
<td>$40 copay for psychiatric services (group and individual)</td>
</tr>
<tr>
<td>Physician/Practitioner services, including doctor’s office visits</td>
<td>$9 copay PCP office visit</td>
<td>$10 copay PCP office visit</td>
</tr>
<tr>
<td></td>
<td>$50 copay Specialist office visit</td>
<td>$50 copay Specialist office visit</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF) care</td>
<td>You pay a $0 copay for days 1 through 20</td>
<td>You pay a $0 copay for days 1 through 20</td>
</tr>
<tr>
<td></td>
<td>$172 copay per day for days 21 through 100.</td>
<td>$178 copay per day for days 21 through 100.</td>
</tr>
<tr>
<td>Cost</td>
<td>2019 (this year)</td>
<td>2020 (next year)</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Telehealth services</td>
<td>Non-Medicare covered Telehealth services are not covered.</td>
<td>$10 copay for non-Medicare covered Telehealth services</td>
</tr>
<tr>
<td>Special Supplemental Benefits for the Chronically Ill</td>
<td>Special supplemental benefits for the chronically ill are not covered.</td>
<td>Hypertension:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transportation - 2 follow up appointments per discharge (within the first 7 and 14 days) with a max of 24 one way trips</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transportation - 2 follow up appointments per discharge (within the first 7 and 14 days) with a max of 24 one way trips</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Podiatry - Waiver of copay for a preventative exam</td>
</tr>
<tr>
<td>Vision care</td>
<td>$50 copay for diabetic retinal exams</td>
<td>$0 copay for retinal exams</td>
</tr>
<tr>
<td></td>
<td>$0 copay for eyeglass frames up to $100 every two years; 20% discount on balance over $100</td>
<td>$0 copay for eyeglass frames, lens and options package up to $100 every year or Contact Lenses: $0 copay up to $100 allowance.</td>
</tr>
<tr>
<td></td>
<td>Conventional Contact Lenses: $0 copay up to $100 allowance; 15% discount on balance over $100</td>
<td></td>
</tr>
</tbody>
</table>
Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically. You can also get the Drug List by calling Member Services at 1-844-607-2827 (TTY: 1-800-750-0750 or 711) or visiting our website (CareSource.com/Medicare).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  
  - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Services.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Any current formulary exceptions you may have will still be covered next year through the expiration date provided in the original approval letter or until you are no longer covered by the plan, whichever occurs first.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2020, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the
change 30 days before we make it or get a month’s supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

### Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs (“Extra Help”), the information about costs for Part D prescription drugs may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by September 30, 2019, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 7.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the Evidence of Coverage, which is located on our website at CareSource.com/Medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.)

### Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>The deductible is $250.</td>
<td>The deductible is $150.</td>
</tr>
<tr>
<td></td>
<td>During this stage, you pay the full cost of your Tier 3, 4, &amp; 5 drugs until you have reached the yearly deductible.</td>
<td>During this stage, you pay $6.00 per prescription cost-sharing for drugs on Tier 1 and $15.00 per prescription cost-sharing for drugs on Tier 2. You</td>
</tr>
</tbody>
</table>

During this stage, you pay $5.00 per prescription cost-sharing for drugs on Tier 1 and $15.00 per prescription cost-sharing for drugs on Tier 2. You
### Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.*

<table>
<thead>
<tr>
<th>Stage</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you <strong>pay your share of the cost.</strong></td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
</tr>
<tr>
<td></td>
<td>Tier 1 Preferred Generic: You pay $6.00</td>
<td>Tier 1 Preferred Generic: You pay $5.00</td>
</tr>
<tr>
<td></td>
<td>Tier 2 Generic: You pay $15.00</td>
<td>Tier 2 Generic: You pay $15.00</td>
</tr>
<tr>
<td></td>
<td>Tier 3 Preferred Brand: You pay $47.00</td>
<td>Tier 3 Preferred Brand: You pay $45.00</td>
</tr>
<tr>
<td></td>
<td>Tier 4 Non-Preferred Drug: You pay $100.00</td>
<td>Tier 4 Non-Preferred Drug: You pay $100.00</td>
</tr>
<tr>
<td></td>
<td>Tier 5 Specialty Tier: You pay 28%</td>
<td>Tier 5 Specialty Tier: You pay 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).</td>
<td>Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).</td>
</tr>
</tbody>
</table>
Changes to the Coverage Gap and Catastrophic Coverage Stages

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

## SECTION 2 Administrative Changes

<table>
<thead>
<tr>
<th>Process</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization may be required.</td>
<td>• Occupational Therapy, Speech Therapy, and Physical Therapy</td>
<td>• Occupational Therapy, Speech Therapy, and Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for more than 3 visits per year in home setting.</td>
<td>Prior authorization is required for more than 10 visits per year in home setting.</td>
</tr>
<tr>
<td></td>
<td>• Occupational Therapy, Speech Therapy, and Physical Therapy</td>
<td>• Occupational Therapy, Speech Therapy, and Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for more than 30 visits per year.</td>
<td>Prior authorization is required for more than 10 visits per year.</td>
</tr>
<tr>
<td></td>
<td>• Intensive Outpatient Program Services</td>
<td>• Intensive Outpatient Program Services</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is not required.</td>
<td>Prior authorization required for greater than 10 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>• DME/Prosthetics/Medical Supplies</td>
<td>• DME/Prosthetics/Medical Supplies</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all powered and customized wheelchairs.</td>
<td>Prior authorization is required for all powered and customized wheelchairs.</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is also required for other DME categories if</td>
<td>Prior authorization is also required for other DME categories if</td>
</tr>
</tbody>
</table>
SECTION 3  Deciding Which Plan to Choose

Section 3.1 – If you want to stay in CareSource Advantage Zero Premium

To stay in our plan you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices
- You can join a different Medicare health plan timely,
- OR -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2020, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click “Find health & drug plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.
As a reminder, CareSource offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

**Step 2: Change your coverage**

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from CareSource Advantage Zero Premium.

- To change **to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from CareSource Advantage Zero Premium.

- To change **to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - or – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

### SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2020.

**Are there other times of the year to make a change?**

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

### SECTION 5 Programs That Offer Free Counseling about Medicare

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

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

**SECTION 6 Programs That Help Pay for Prescription Drugs**

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

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

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Ohio HIV Drug Assistance Program (OHDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ohio HIV Drug Assistance Program (OHDAP) at 1-800-777-4775 (TTY 711).

**SECTION 7 Questions?**

**Section 7.1 – Getting Help from CareSource Advantage Zero Premium**

Questions? We’re here to help. Please call Member Services at 1-844-607-2827. (TTY only, call 1-800-750-0750 or 711.) We are available for phone calls October 1 – March 31: 8 a.m. – 8 p.m., Monday through Sunday; April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday. Calls to these numbers are free.

**Read your 2020 Evidence of Coverage (it has details about next year’s benefits and costs)**

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 Evidence of Coverage for CareSource Advantage Zero
Premium. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at [caresource.com/plans/medicare/plan-documents](caresource.com/plans/medicare/plan-documents). You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

**Visit our Website**

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

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**Section 7.2 – Getting Help from Medicare**

To get information directly from Medicare:

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

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

**Visit the Medicare Website**

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

**Read Medicare & You 2020**

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website ([https://www.medicare.gov](https://www.medicare.gov)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
If you, or someone you’re helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-607-2827 TTY:711.
CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-844-607-2827 TTY:711.

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

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

CivilRightsCoordinator@CareSource.com

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

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

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

Member Services
1-844-607-2827 (TTY: 1-800-750-0750 or 711)
October 1 – March 31: 8 a.m. to 8 p.m., seven days a week
April 1 – September 30: 8 a.m. to 8 p.m., Monday – Friday

CareSource.com/Medicare