

CareSource Dual Advantage™ (HMO D-SNP)

# 2021 SUMMARY OF BENEFITS

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***Service Area //***

Boone, Clinton, Delaware, Hendricks,  
Henry, Howard, Kosciusko, Madison,  
Marshall, Rush, Shelby, Tipton

# 2021 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 for over 30 years. Our mission is to make a lasting difference in our members' lives by improving their health and well-being. CareSource Dual Advantage™ (HMO D-SNP) gives you more benefits, more savings, more care... and no hidden costs.

### More benefits than basic Medicare

Our Medicare D-SNP plan (Part C) provides you with all the benefits of Part A and Part B, plus prescription drug coverage (Part D). But we're about more than basic Medicare. Our plan is designed to provide you with the best care, additional benefits such as dental and vision care, and save you money.

## 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, ask the other plans for their Summary of Benefits booklets. Or, 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 your current "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.

## YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining CareSource Dual Advantage.

## ABOUT THE PLAN

CareSource Dual Advantage is a Medicare Advantage HMO plan with a Medicare contract. To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed on page 3, and be a United States citizen or lawfully present in the United States.

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medicaid. How much Medicaid covers depends on your income, resources and other factors. Some people get full Medicaid benefits. Some only get help to pay for certain Medicare costs, which may include premiums, deductibles, coinsurance, or copays.

You can enroll in this plan if you are in one of these Medicaid categories:

- **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. You pay nothing, except for Part D prescription drug copays.
- **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. You pay nothing, except for Part D prescription drug copays.
- **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.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease.

**You must recertify your Medicaid enrollment to continue to receive your Medicaid coverage.**

## WHO CAN JOIN?

To join CareSource Dual Advantage you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. You must also be enrolled in Indiana Medicaid.

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

Boone, Clinton, Delaware, Hendricks, Henry, Howard, Kosciusko, Madison, Marshall, Rush, Shelby, Tipton

## 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 not in 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/Medicare](https://www.caresource.com/Medicare) 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.

## WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers — and more. Some of the extra benefits are outlined in this booklet.

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/Medicare](https://www.caresource.com/Medicare).

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan drug list (list of Part D drugs) and any restrictions on our website, [CareSource.com/Medicare](https://www.caresource.com/Medicare). Or, call us and we will send you a copy of the drug list.

# Questions?

If you are a member of this plan, call us toll-free at 1-833-230-2020 (TTY: 711).

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

You can also visit our website at [CareSource.com/Medicare](https://www.CareSource.com/Medicare).

## Hours of Operation

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

## Customer Service

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 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 711.)

| MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS                                         |                                                                       |
|--------------------------------------------------------------------------------|-----------------------------------------------------------------------|
|                                                                                | CareSource Dual Advantage                                             |
| Monthly Premium                                                                | \$0                                                                   |
| Annual Deductible                                                              | \$0                                                                   |
| Annual Out-of-Pocket Maximum<br>(the limit on how much you will pay in a year) | \$0 annually for Medicare-covered services from in-network providers. |

## CareSource Dual Advantage (HMO D-SNP) 2021 Summary of Benefits Chart

Cost sharing for Medicare covered benefits in the chart below are based on your level of Indiana Medicaid eligibility.

### COVERED MEDICAL AND HOSPITAL BENEFITS — IN-NETWORK ONLY

If you use providers that are not in our network, we may not pay for these services.

|                                                                  | CareSource Dual Advantage                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient Hospital Care <sup>1</sup>                             | Days 1 through 7<br>\$0 copay per day                                                                                                                                                                                                                                       |
|                                                                  | Days 8 through 90<br>\$0 copay per day                                                                                                                                                                                                                                      |
| Outpatient Hospital <sup>1</sup>                                 | <b>Ambulatory surgical center</b>                                                                                                                                                                                                                                           |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Outpatient hospital</b>                                                                                                                                                                                                                                                  |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
| Doctor's Office Visits                                           | <b>Primary care physician visit</b> (Including Telehealth Visit)                                                                                                                                                                                                            |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Specialist visit</b>                                                                                                                                                                                                                                                     |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
| Preventive Care                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
| Emergency Care                                                   | 0% coinsurance<br>Coinsurance is waived if you are admitted to the hospital within 3 days for the same condition. You pay the inpatient hospital cost share instead of the emergency cost share. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| Urgent Care                                                      | \$0 copay                                                                                                                                                                                                                                                                   |
| Diagnostic Tests, Lab/Radiology Services and X-Rays <sup>1</sup> | <b>Diagnostic tests and procedures</b>                                                                                                                                                                                                                                      |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Lab services</b>                                                                                                                                                                                                                                                         |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Diagnostic radiology services</b> (such as MRIs, CT scans)                                                                                                                                                                                                               |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Therapeutic radiology services</b> (such as radiation treatment for cancer)                                                                                                                                                                                              |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |
|                                                                  | <b>Outpatient x-rays</b>                                                                                                                                                                                                                                                    |
|                                                                  | \$0 copay                                                                                                                                                                                                                                                                   |

Services with a <sup>1</sup> may require prior authorization. Services with a <sup>2</sup> are not subject to the maximum out of pocket. Amounts shown are what you pay. Services are covered in-network only except for emergency care and ambulance.

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

If you use providers that are not in our network, we may not pay for these services.

|                                                 | CareSource Dual Advantage                                                                                                                                                                                                                         |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing Services</b>                         | <b>Exam to diagnose and treat hearing and balance issues</b>                                                                                                                                                                                      |
|                                                 | \$0 copay                                                                                                                                                                                                                                         |
|                                                 | <b>Routine hearing exam</b>                                                                                                                                                                                                                       |
|                                                 | \$0 copay, 1 every year                                                                                                                                                                                                                           |
|                                                 | <b>Hearing aid fitting/evaluation</b>                                                                                                                                                                                                             |
|                                                 | \$0 copay, 3 every year                                                                                                                                                                                                                           |
|                                                 | <b>Hearing aid<sup>2</sup></b>                                                                                                                                                                                                                    |
|                                                 | \$1000 allowance per hearing aid; one aid per ear per year                                                                                                                                                                                        |
| <b>Dental Services — Medicare-Covered</b>       | \$0 copay<br>Excludes services in connection with care, treatment, filling, removal or replacement of teeth                                                                                                                                       |
| <b>Comprehensive Dental<sup>1, 2</sup></b>      | \$0 copay for simple extractions, minor restorations, periodontics and other non-Medicare covered comprehensive dental services<br>\$2,000 maximum plan coverage amount for comprehensive dental benefits every year                              |
| <b>Dental Services<sup>2</sup> — Preventive</b> | \$0 copay for a single office visit that includes: <ul style="list-style-type: none"> <li>– Cleaning (1 cleaning every six months)</li> <li>– Dental x-ray(s) (1 x-ray every year)</li> <li>– Oral exam (1 oral exam every six months)</li> </ul> |
| <b>Vision Services</b>                          | <b>Exam to diagnose and treat diseases and conditions of the eye</b>                                                                                                                                                                              |
|                                                 | \$0 copay                                                                                                                                                                                                                                         |
|                                                 | <b>Routine eye exam (1 every year)</b>                                                                                                                                                                                                            |
|                                                 | \$0 copay                                                                                                                                                                                                                                         |
|                                                 | <b>Eyewear<sup>2</sup></b>                                                                                                                                                                                                                        |
|                                                 | \$0 copay, up to \$250 allowance                                                                                                                                                                                                                  |
|                                                 | <b>Eyeglasses or contact lenses after cataract surgery</b>                                                                                                                                                                                        |
|                                                 | \$0 copay                                                                                                                                                                                                                                         |

Services with a <sup>1</sup> may require prior authorization. Services with a <sup>2</sup> are not subject to the maximum out of pocket. Amounts shown are what you pay. Services are covered in-network only except for emergency care and ambulance.

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

If you use providers that are not in our network, we may not pay for these services.

|                                                                                                                        | CareSource Dual Advantage                                                                                              |
|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Mental Health Care<sup>1</sup></b><br>Lifetime limit:<br>Up to 190 days inpatient care<br>in a psychiatric hospital | <b>Inpatient visit</b>                                                                                                 |
|                                                                                                                        | Days 1 through 7<br>\$0 copay per day                                                                                  |
|                                                                                                                        | Days 8 through 90<br>\$0 copay per day                                                                                 |
|                                                                                                                        | <b>Outpatient group therapy visit (psychiatrist provided)</b>                                                          |
|                                                                                                                        | \$0 copay                                                                                                              |
|                                                                                                                        | <b>Outpatient individual therapy visit (psychiatrist provided)</b>                                                     |
|                                                                                                                        | \$0 copay                                                                                                              |
| <b>Skilled Nursing Facility<sup>1</sup></b><br>Limited to 100 days per<br>benefit period                               | Days 1 through 20<br>\$0 copay per day                                                                                 |
|                                                                                                                        | Days 21 through 100<br>\$0 copay                                                                                       |
| <b>Outpatient Rehabilitation<sup>1</sup></b>                                                                           | <b>Cardiac (heart) rehab services</b>                                                                                  |
|                                                                                                                        | \$0 copay                                                                                                              |
|                                                                                                                        | <b>Occupational therapy visit</b>                                                                                      |
|                                                                                                                        | \$0 copay                                                                                                              |
|                                                                                                                        | <b>Physical therapy and speech and language therapy visit</b>                                                          |
|                                                                                                                        | \$0 copay                                                                                                              |
|                                                                                                                        | <b>Supervised Exercise Therapy (SET)</b>                                                                               |
|                                                                                                                        | \$0 copay                                                                                                              |
| <b>Ambulance<sup>1</sup></b>                                                                                           | \$0 copay                                                                                                              |
| <b>Medicare Part B Drugs<sup>1</sup></b>                                                                               | \$0 copay                                                                                                              |
| <b>Foot Care</b> (podiatry services)                                                                                   | \$0 copay<br>Includes foot exams and treatment if you have diabetes-related<br>nerve damage or meet certain conditions |
| <b>Durable Medical Equipment<sup>1</sup></b><br>(wheelchairs, oxygen, etc.)                                            | \$0 copay                                                                                                              |
| <b>Prosthetic Devices<sup>1</sup></b><br>(braces, artificial limbs, etc.)                                              | <b>Prosthetic devices</b>                                                                                              |
|                                                                                                                        | \$0 copay                                                                                                              |
|                                                                                                                        | <b>Related medical supplies</b>                                                                                        |
|                                                                                                                        | \$0 copay                                                                                                              |

Services with a <sup>1</sup> may require prior authorization. Services with a <sup>2</sup> are not subject to the maximum out of pocket. Amounts shown are what you pay. Services are covered in-network only except for emergency care and ambulance.

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

If you use providers that are not in our network, we may not pay for these services.

|                                                   | CareSource Dual Advantage                                                                                                                                                                                            |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diabetes Supplies and Services</b>             | <b>Diabetes monitoring supplies</b>                                                                                                                                                                                  |
|                                                   | \$0 copay                                                                                                                                                                                                            |
|                                                   | <b>Diabetes self-management training</b>                                                                                                                                                                             |
|                                                   | \$0 copay                                                                                                                                                                                                            |
|                                                   | <b>Therapeutic shoes or inserts</b>                                                                                                                                                                                  |
|                                                   | \$0 copay                                                                                                                                                                                                            |
| <b>Chiropractic Care<sup>1</sup></b>              | \$0 copay<br>Includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position)                                                                          |
| <b>Acupuncture</b><br>(for chronic low back pain) | \$0 copay                                                                                                                                                                                                            |
| <b>Home Health Care<sup>1</sup></b>               | \$0 copay                                                                                                                                                                                                            |
| <b>Hospice</b>                                    | 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.<br>Please contact us for more details. |
| <b>Outpatient Substance Abuse<sup>1</sup></b>     | <b>Group therapy visit</b>                                                                                                                                                                                           |
|                                                   | \$0 copay                                                                                                                                                                                                            |
|                                                   | <b>Individual therapy visit</b>                                                                                                                                                                                      |
|                                                   | \$0 copay                                                                                                                                                                                                            |
| <b>Over-the-Counter Items</b>                     | \$0 copay<br>Plan covers up to \$125 every three months. Unused portions do not carry over to the next period.                                                                                                       |
| <b>Renal Dialysis<sup>1</sup></b>                 | \$0 copay                                                                                                                                                                                                            |

Services with a <sup>1</sup> may require prior authorization. Services with a <sup>2</sup> are not subject to the maximum out of pocket. Amounts shown are what you pay. Services are covered in-network only except for emergency care and ambulance.

## MEDICAID BENEFITS

The following chart provides information for individuals with Medicare and Medicaid. Your services are paid first by Medicare and then by Medicaid.

The benefits described below are covered by Medicaid. You can see what Indiana Medicaid covers and what our plan covers. If a benefit is used up or not covered by Medicare, then Medicaid may provide coverage. This depends on your type of Medicaid coverage.

Coverage of the benefits described below depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is, CareSource Dual Advantage will cover the benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Indiana Medicaid, 1-800-457-4584.

Medicaid may pay your Medicare cost sharing amount, but it will depend on your Medicaid eligibility level. If Medicare doesn't cover a service or a benefit has run out, Medicaid may help, but you may have to pay a cost share.

| Benefit                           |                                                                                                                     | Indiana Medicaid | CareSource Dual Advantage |
|-----------------------------------|---------------------------------------------------------------------------------------------------------------------|------------------|---------------------------|
| Institutional and Clinic Services | Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center  | Covered          | Covered                   |
|                                   | Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics | Covered          | Covered                   |
|                                   | Federally Qualified Health Center Services                                                                          | Covered          | Covered                   |
|                                   | Inpatient Hospital Services, other than in an institution for Mental Diseases                                       | Covered          | Covered                   |
|                                   | Outpatient Hospital Services                                                                                        | Covered          | Covered                   |
|                                   | Rehabilitation Services: Mental Health and Substance Abuse                                                          | Covered          | Covered                   |
|                                   | Rural Health Clinic Services                                                                                        | Covered          | Covered                   |
| Practitioner Services             | Certified Registered Nurse Anesthetist Services                                                                     | Covered          | Covered                   |
|                                   | Chiropractor Services                                                                                               | Covered          | Covered                   |

| Benefit                             |                                                     | Indiana Medicaid | CareSource Dual Advantage |
|-------------------------------------|-----------------------------------------------------|------------------|---------------------------|
|                                     | Dental Services                                     | Covered          | Covered                   |
|                                     | Medical and Remedial Care - Other Practitioners     | Covered          | Covered                   |
|                                     | Medical/Surgical Services of a Dentist              | Covered          | Covered                   |
|                                     | Nurse Midwife Services                              | Covered          | Covered                   |
|                                     | Nurse Practitioner Services                         | Covered          | Covered                   |
|                                     | Optometrist Services                                | Covered          | Covered                   |
|                                     | Physician Services                                  | Covered          | Covered                   |
|                                     | Podiatrist Services                                 | Covered          | Covered                   |
|                                     | Psychologist Services                               | Covered          | Covered                   |
| Prescription Drugs                  | Prescription Drugs                                  | Covered          | Covered                   |
| Physical Therapy and Other Services | Occupational Therapy Services                       | Covered          | Covered                   |
|                                     | Physical Therapy Services                           | Covered          | Covered                   |
|                                     | Services for Speech, Hearing and Language Disorders | Covered          | Covered                   |
| Products and Devices                | Dentures                                            | Covered          | Covered                   |
|                                     | Eyeglasses                                          | Covered          | Covered                   |
|                                     | Hearing Aids                                        | Covered          | Covered                   |
|                                     | Medical Equipment and Supplies                      | Covered          | Covered                   |
|                                     | Prosthetic and Orthotic Devices                     | Covered          | Covered                   |

| Benefit                 |                                                                                                                                  | Indiana Medicaid | CareSource Dual Advantage |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------|
| Transportation Services | Ambulance Services                                                                                                               | Covered          | Covered                   |
|                         | Non-Emergency Medical Transportation Services                                                                                    | Covered          | Covered                   |
| Other Services          | Diagnostic, Screening and Preventive Services                                                                                    | Covered          | Covered                   |
|                         | Early Periodic Screening, Diagnosis and Treatment                                                                                | Covered          | Not Covered               |
|                         | Extended services for Pregnant Women                                                                                             | Covered          | Not Covered               |
|                         | Family Planning Services                                                                                                         | Covered          | Not Covered               |
|                         | Laboratory and X-Ray Services, outside Hospital or Clinic                                                                        | Covered          | Covered                   |
|                         | Targeted Case Management                                                                                                         | Covered          | Covered                   |
|                         | Long-Term Care Services                                                                                                          | Covered          | Not Covered               |
| Community Based Care    | Home and Community Based Services Waiver                                                                                         | Covered          | Covered                   |
|                         | Home Health Services, Includes nursing services, home health aides, and medical supplies/equipment                               | Covered          | Covered                   |
|                         | Hospice Care                                                                                                                     | Covered          | Covered                   |
|                         | Personal Care Services                                                                                                           | Not Covered      | Not Covered               |
|                         | Private Duty Nursing Services                                                                                                    | Not Covered      | Not Covered               |
|                         | Program of All-Inclusive Care for the Elderly                                                                                    | Not Covered      | Not Covered               |
| Institutional Care      | Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases, age 65 and old | Covered          | Covered                   |

| Benefit |                                                                             | Indiana Medicaid | CareSource Dual Advantage |
|---------|-----------------------------------------------------------------------------|------------------|---------------------------|
|         | Inpatient Psychiatric Services, under age 21                                | Covered          | Covered                   |
|         | Intermediate Care Facility Services for the Mentally Retarded               | Covered          | Covered                   |
|         | Nursing Facility Services, other than in an Institution for Mental Diseases | Covered          | Covered                   |
|         | Religious Non-Medical Health Care Institution and Practitioner Services     | Covered          | Covered                   |

# PRESCRIPTION DRUG BENEFITS (INITIAL COVERAGE) — IN-NETWORK ONLY

## CareSource Dual Advantage

Part B Drugs<sup>1</sup>  
(such as chemotherapy)

\$0 copay

Part D Drugs — Retail<sup>1</sup>

### 1-month supply or 3-month supply

Tier 1 (Preferred Generic)

25% of the total cost or applicable Low Income Subsidy (LIS) copay  
\*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution

Tier 2 (Generic)

25% of the total cost or applicable Low Income Subsidy (LIS) copay  
\*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution

Tier 3 (Preferred Brand)

25% of the total cost or applicable Low Income Subsidy (LIS) copay  
\*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution

Tier 4 (Non-Preferred Drug)

25% of the total cost or applicable Low Income Subsidy (LIS) copay  
\*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution

Tier 5 (Specialty Tier)

25% of the total cost or applicable Low Income Subsidy (LIS) copay  
(3-month supply is not covered)

Tier 6 (Select Care Drugs)

\$0 copay or applicable Low Income Subsidy (LIS) copay  
(3-month supply is not covered)

**3-month supply**

|                              |                                                                                                                                                                                          |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tier 1 (Preferred Generic)   | 25% of the total cost or applicable Low Income Subsidy (LIS)<br>copay<br>*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution |
| Tier 2 (Generic)             | 25% of the total cost or applicable Low Income Subsidy (LIS)<br>copay<br>*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution |
| Tier 3 (Preferred Brand)     | 25% of the total cost or applicable Low Income Subsidy (LIS)<br>copay<br>*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution |
| Tier 4 (Non-Preferred Brand) | 25% of the total cost or applicable Low Income Subsidy (LIS)<br>copay<br>*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution |
| Tier 5 (Specialty Tier)      | Not covered                                                                                                                                                                              |
| Tier 6 (Select Care Drugs)   | Not covered                                                                                                                                                                              |

## LIS Cost Sharing Chart for Initial Coverage phase

### Low Income Subsidy (LIS) or “Extra Help” cost sharing

#### Part D Drugs – Retail: 1-month supply or 3-month supply

#### Part D Drugs – Standard Mail Order: 3-month supply

\*Specialty medications are limited to a 30-day supply and/or may only be available through limited distribution

| LIS Level                                     | Drug Type | Cost Sharing    |
|-----------------------------------------------|-----------|-----------------|
| Federal Poverty Level (FPL) Institutionalized | Generic   | \$0 copay       |
|                                               | Brand     | \$0 copay       |
| Federal Poverty Level (FPL) <100%             | Generic   | \$1.30 copay    |
|                                               | Brand     | \$4.00 copay    |
| Federal Poverty Level (FPL) >100%             | Generic   | \$3.70 copay    |
|                                               | Brand     | \$9.20 copay    |
| Federal Poverty Level (FPL) 135-149%          | Generic   | 15% coinsurance |
|                                               | Brand     | 15% coinsurance |

### Prescription drugs with a <sup>1</sup> may require prior authorization.

CareSource Dual Advantage members receive “Extra Help” so copay depends on income and institutional status.

Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us toll-free at **1-833-230-2020 (TTY: 711)** or access our website [CareSource.com/Medicare](https://www.caresource.com/Medicare).

The drug list, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

| ADDITIONAL BENEFITS                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                  | CareSource Dual Advantage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Meals</b>                                     | Two meals a day for 14 days after an inpatient hospitalization                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Transportation</b>                            | \$0 copay, 60 one-way trips annually                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Fitness</b>                                   | \$0 copay<br>No cost memberships at participating fitness centers or free home fitness kits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Worldwide ER and Urgent Care</b>              | <b>Emergency Care</b> (waived if admitted)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                  | \$0 copay, \$10,000 maximum plan benefit coverage amount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                  | <b>Urgent Care</b><br>\$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>CareSource24® — 24 Hour Nurse Advice Line</b> | <p>You can call CareSource24® any time of the night or day — 24 hours a day, 7 days a week — to talk with a caring, experienced registered nurse. You can find the toll-free number on the back of your CareSource member ID card. 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 medicines</li> <li>– Learn about healthy eating and staying well</li> </ul> |
| <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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

This information is not a complete description of benefits. Call **1-833-230-2020 (TTY: 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.

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 Dual Advantage is an HMO with a Medicare contract. Enrollment in CareSource Dual Advantage depends on contract renewal.

**Services with a <sup>1</sup> may require prior authorization. Services with a <sup>2</sup> are not subject to the maximum out of pocket. Amounts shown are what you pay. Services are covered in-network only except for emergency care and ambulance.**



**CareSource.com/DSNP**

# 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: **1-833-230-2020 (TTY: 711)**.



## UNDERSTANDING THE BENEFITS

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Call **1-833-230-2020 (TTY: 711)** or visit **CareSource.com/DSNP** 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## UNDERSTANDING IMPORTANT RULES

- ☐ In addition to your monthly plan premium, 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/coinsurance may change on January 1 of each year.
- ☐ 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 (HMO 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 + (QMB+), or Full-Benefit Dual Eligible (FBDE).



# 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 work to 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 (things like a Low-Income Subsidy Rider if you're qualified). 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** 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. You will need to show both your CareSource Member ID card and your Medicaid card each time you get medical, dental, vision or 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: 711)** to have a new card mailed to you. Member Services' hours are: 8 a.m. – 8 p.m., seven days a week from Oct. 1 – Mar. 31 and the same hours Monday – Friday the rest of the year.



**3. YOU'LL RECEIVE A HEALTH NEEDS ASSESSMENT (HNA)** as part of your new member kit. The HNA is a free 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. There is a \$15 reward added to a member's My CareSource Rewards card for completion of the HNA.

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 Member Services at **1-833-230-2020 (TTY: 711)**.



**4. 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 you complete your HNA, address special medical problems, coordinate your health care needs and more!

## 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 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  
PO 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 1-844-607-2830.  
TTY users can call 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 1-844-607-2830 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

## 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)<br>(   /   /   )                                                                                                                |  | Sex:<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  | Phone number:<br>(   )          |  |
| Permanent Residence street address (Don't enter a PO Box)<br>Street Address:                                                                             |  |                                                                       |  |                                 |  |
| City:                                                                                                                                                    |  | County:                                                               |  | State:                          |  |
|                                                                                                                                                          |  |                                                                       |  | ZIP Code:                       |  |
| Mailing address, if different from your permanent address (PO Box allowed)<br>Street Address:                                                            |  |                                                                       |  |                                 |  |
| City:                                                                                                                                                    |  | County:                                                               |  | 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                       |  |                                 |  |
| Name of other coverage:                                                                                                                                  |  | Member number for this coverage:                                      |  | Group number for this coverage: |  |
|                                                                                                                                                          |  |                                                                       |  |                                 |  |
| Are you presently on Medicaid?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                               |  |                                                                       |  |                                 |  |
| If yes, is your eligibility level one of the following:<br><input type="checkbox"/> QMB <input type="checkbox"/> QMB+ <input type="checkbox"/> FBDE      |  |                                                                       |  |                                 |  |

## IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a CareSource Medicare Advantage plan.
- By joining this Medicare Advantage Plan, 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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.
- 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:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) 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.**

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.

☐ Large Print

Please contact CareSource at 1-844-607-2827 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. EST, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

### PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 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.



P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com/Medicare

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period 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 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 (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 (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 Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)\_\_\_\_\_.
- ☐ I recently left a PACE program on (insert date)\_\_\_\_\_.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (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 applies to you or you're not sure, please contact CareSource at **1-844-607-2827** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31, and the same hours Monday through Friday the rest of the year.