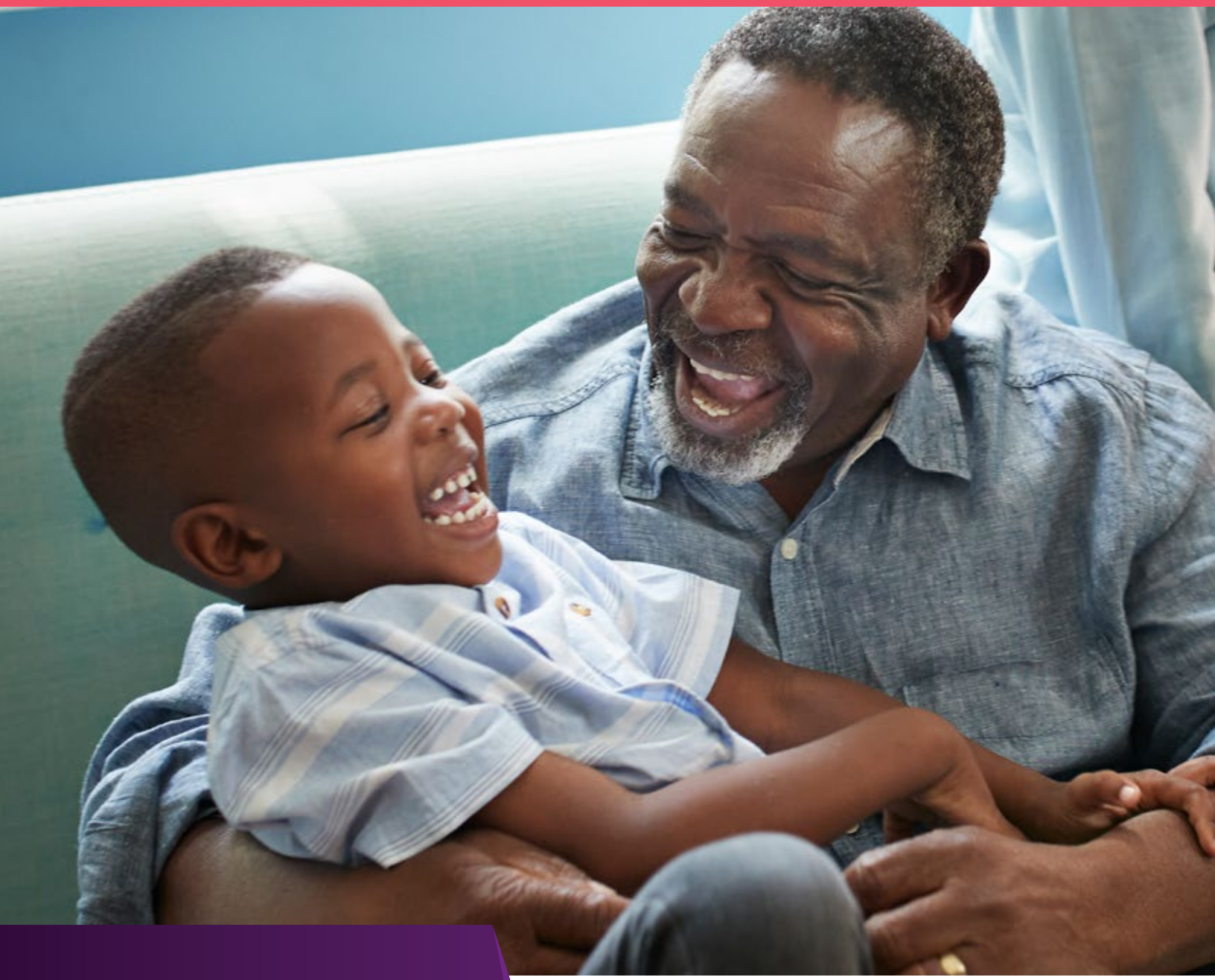
CareSource Dual Advantage™ (HMO D-SNP)

2022 ANNUAL NOTICE OF CHANGE



CareSource®
OHIO

Service Area // Adams, Athens, Brown, Champaign, Clark, Columbiana, Darke, Defiance, Delaware, Fairfield, Fayette, Fulton, Gallia, Greene, Hamilton, Hocking, Huron, Lake, Lucas, Madison, Mahoning, Medina, Mercer, Miami, Monroe, Morgan, Muskingum, Pickaway, Richland, Sandusky, Seneca, Shelby, Trumbull, Union, Van Wert, Williams, Wood, Wyandot

CareSource Dual Advantage™ (HMO D-SNP) offered by CareSource Ohio, Inc.

Annual Notice of Changes for 2022

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

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 and 2 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 2022 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 go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. 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.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 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 don't join another plan by December 7, 2021, you will be enrolled in CareSource Dual Advantage.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 3 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in CareSource Dual Advantage.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at **1-833-230-2020** for additional information (TTY users should call **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 **1-833-230-2020** (TTY users should call **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About CareSource Dual Advantage

- CareSource Ohio, Inc. (HMO D-SNP) is an HMO with a Medicare contract. Enrollment in CareSource Dual Advantage depends on contract renewal. CareSource Dual Advantage is a Medicare product only. It is not a fully integrated plan.
- When this booklet says "we," "us," or "our," it means CareSource Ohio, Inc. (CareSource). When it says "plan" or "our plan," it means CareSource Dual Advantage.

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for CareSource Dual Advantage 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*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays 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.	$0 copay	$0 copay

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage **(See Section 1.6 for details.)**	Deductible: $445 for drugs on Tiers 1, 2, 3, 4, and 5 only Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25% of the total cost • Drug Tier 2: 25% of the total cost • Drug Tier 3: 25% of the total cost • Drug Tier 4: 25% of the total cost • Drug Tier 5: 25% of the total cost • Drug Tier 6: $0 copay	Deductible: $480 for drugs on Tiers 1, 2, 3, 4, and 5 only Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25% of the total cost • Drug Tier 2: 25% of the total cost • Drug Tier 3: 25% of the total cost • Drug Tier 4: 25% of the total cost • Drug Tier 5: 25% of the total cost • Drug Tier 6: $0 copay
Maximum out-of-pocket amount 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.)	$0	$0

Annual Notice of Changes for 2022
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. **Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.**	$0	$0

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 2022 *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 to manage 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 2022 *Provider & Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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, *Benefits Chart (what is covered)*, in your *2022 Evidence of Coverage.* 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.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Annual Physical Exam	**In-Network** Annual Physical Exam is not covered	**In-Network** You pay $0 copay for an annual physical exam.
Cardiac Rehabilitation Services (Medicare-covered)	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Chiropractic Services (Medicare-covered)	**In-Network** Prior authorization is required for greater than 15 visits per year.	**In-Network** Prior authorization is not required.

Cost	2021 (this year)	2022 (next year)
Dental Services (Non-Medicare-covered Comprehensive)	**In-Network** $1,500 maximum plan coverage amount for comprehensive dental benefits every year	**In-Network** $3,000 maximum plan coverage amount for preventive and comprehensive dental benefits every year
Dental Services (Preventive)	**In-Network** Dental Services (Preventive) does not have a maximum plan coverage amount.	**In-Network** $3,000 maximum plan coverage amount for preventive and comprehensive dental benefits every year
Diabetic Services and Supplies	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Durable Medical Equipment (DME) and Related Supplies	**In-Network** Prior authorization is required for all powered and customized wheelchairs. Prior authorization is also required for other DME categories if billed charges are greater than $500.	**In-Network** Prior authorization is required.
Health and Wellness Education Programs	**In-Network** You pay $0 copay for physical fitness program.	**In-Network** You pay $0 copay for physical fitness program, memory fitness program, and activity tracker.
Hearing Aids	**In-Network** Covered up to $1,000 toward the cost of 2 non-implantable hearing aid[s] from the applicable TruHearing Choice catalogue every 1 year	**In-Network** Covered up to $1,000 toward the cost of each non-implantable hearing aid[s] from the applicable TruHearing Choice catalogue every 1 year

Cost	2021 (this year)	2022 (next year)
	(limit 1 hearing aid per ear).	(limit 1 hearing aid per ear).
Home Health Agency Care	**In-Network** Prior authorization is required for all Private Duty and Home Health Aide visits. Prior authorization is required for Skilled Nursing home services greater than 3 visits per year. Prior authorization is required for social worker home services greater than 2 visits per year.	**In-Network** Prior authorization is required.
Home Infusion Therapy Services	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Kidney Dialysis Services	**In-Network** Prior authorization is required for certain services.	**In-Network** Prior authorization is not required.
Meal Benefit	**In-Network** Meal benefit is only offered following an inpatient stay. Limited to 2 meals per day for up to 14 days post inpatient discharge.	**In-Network** Meal benefit is only offered following an inpatient stay. Limited to 2 meals per day for up to 14 days per inpatient discharge. Maximum annual benefit is $2,400.
Medical Supplies	**In-Network** Prior authorization is required for greater than $500 billed charges.	**In-Network** Prior authorization is required.

Cost	2021 (this year)	2022 (next year)
Occupational Therapy Services	**In-Network** Prior authorization is required for greater than 10 visits per calendar year in an outpatient setting.	**In-Network** Prior authorization is required for all visits except evaluations.
Outpatient Blood Services	**In-Network** Three (3) Pint Deductible	**In-Network** Three (3) Pint Deductible is waived
Outpatient Diagnostic Lab Services	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Outpatient Diagnostic Procedures and Tests	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Outpatient Mental Health Specialty Services	**In-Network** Prior authorization is required for Intensive Outpatient Program Services for greater than 10 visits per calendar year. Prior authorization is required for Intensive Outpatient Psychiatric Services for greater than 30 visits per calendar year.	**In-Network** Prior authorization is not required.
Outpatient Substance Abuse Services	**In-Network** Prior authorization is required for Intensive Outpatient Program Services for greater than 10 visits per calendar year. Prior authorization is required for Intensive Outpatient Psychiatric Services for greater than 30 visits per calendar year.	**In-Network** Prior authorization is not required.

Cost	2021 (this year)	2022 (next year)
Over-the-Counter Items	**In-Network** Plan covers up to $150 every three months. Unused portions do not carry over to the next period.	**In-Network** Plan covers up to $350 every three months. Unused portions do not carry over to the next period.
Partial Hospitalization Services	**In-Network** Prior authorization is required for greater than 30 visits.	**In-Network** Prior authorization is required.
Physical & Speech Therapy Services	**In-Network** Prior authorization is required for greater than 10 visits per calendar year in an outpatient setting.	**In-Network** Prior authorization is required.
Prosthetic Devices	**In-Network** Prior authorization is required greater than $500 billed charges.	**In-Network** Prior authorization is required.
Pulmonary Rehabilitation Services (Medicare-covered)	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Supervised Exercise Therapy (SET) (Medicare-covered)	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Vision Care (Non-Medicare-covered Eye wear)	**In-Network** $250 maximum plan coverage amount for routine eye wear every year	**In-Network** $380 maximum plan coverage amount for routine eye wear every year

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.

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.
    - 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 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.

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 does 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. Because you receive "Extra Help," if you haven't received this insert by September 30, 2021 please call Member Services and ask for the "LIS Rider."

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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D Tier 1 Preferred Generic, Tier 2 Generic, Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $445 for drugs on Tiers 1, 2, 3, 4, and 5 only. During this stage, you pay $0 cost sharing for drugs on Tier 6 and the full cost of drugs on Tier 1 Preferred Generic, Tier 2 Generic, Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty Tier until you have reached the yearly deductible.	The deductible is $480 for drugs on Tiers 1, 2, 3, 4, and 5 only. During this stage, you pay $0 cost sharing for drugs on Tier 6 Select Care Drugs and the full cost of drugs on Tier 1 Preferred Generic, Tier 2 Generic, Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty Tier until you have reached the yearly deductible.

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*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage 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 pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
	Tier 1 Preferred Generic: You pay 25% of the total cost.	**Tier 1 Preferred Generic:** You pay 25% of the total cost.
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.	**Tier 2 Generic:** You pay 25% of the total cost.	**Tier 2 Generic:** You pay 25% of the total cost.
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Tier 3 Preferred Brand:** You pay 25% of the total cost.	**Tier 3 Preferred Brand:** You pay 25% of the total cost.
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Tier 4 Non-Preferred Drug:** You pay 25% of the total cost.	**Tier 4 Non-Preferred Drug:** You pay 25% of the total cost.
	Tier 5 Specialty Tier: You pay 25% of the total cost.	**Tier 5 Specialty Tier:** You pay 25% of the total cost.
	Tier 6 Select Care Drugs: You pay $0 copay.	**Tier 6 Select Care Drugs:** You pay $0 copay.

Stage	2021 (this year)	2022 (next year)
	_____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in CareSource Dual Advantage

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 be enrolled in our CareSource Dual Advantage.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *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.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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 Dual Advantage.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CareSource Dual Advantage.
- 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 6.1 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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

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

Ohio Senior Health Insurance Information Program (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. Ohio Senior Health Insurance Information Program (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 Ohio Senior Health Insurance Information Program (OSHIIP) at 1-800-686-1578. You can learn more about Ohio Senior Health Insurance Information Program (OSHIIP) by visiting their website (https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/oshiip).

For questions about your Ohio Department of Medicaid (ODM) benefits, contact Ohio Department of Medicaid (ODM) at 1-800-324-8680 (TTY: 711), 7 a.m. - 8 p.m., Monday through Friday; 8 a.m. - 5 p.m., Saturday. Ask how joining another plan or returning to Original Medicare affects how you get your Ohio Department of Medicaid (ODM) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ohio AIDS Drug Assistance Program (ADAP) at 1-800-777-4775 (TTY: 711).

SECTION 6 Questions?

Section 6.1 – Getting Help from CareSource Dual Advantage

Questions? We're here to help. Please call Member Services at **1-833-230-2020** (TTY only, call **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 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for CareSource Dual Advantage. 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/Medicare**. 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**. 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).

Section 6.2 – 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 (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 www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* 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 (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.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call Ohio Department of Medicaid (ODM) at 1-800-324-8680. TTY users should call 711.

CareSource

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. Please call the member services number on your member ID card.

ARABIC

إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، رجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

AMHARIC

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር እባክዎን በመታወቂያ ካርዱ ላይ ባለው የአገልግሎቶች ቁጥር ይደውሉ።

BURMESE

CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား ခြေးဖျကု ပပြု သကြ်၏ အသကြို ကြ်ကြက်ရေပေါ်ရှိ အသကြို ကြ် ဝက်ေ ငြ်ာင်မှုဝက်ျဝ်[နံက်သိုသို့ တ၍န်]။

CHINESE

如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatiif bilbilaa.

DUTCH

Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

FRENCH (CANADA)

Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d’obtenir gratuitement du soutien et de l’information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Servicenummer auf Ihrer Mitglieder-ID-Karte an

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો િત કરિ મ ટે,કૃપા કરીને તમારા સભ્ય આઈડી કાર્ડ પર સભ્ય સેવા માટે ના નંબર પર ફોન કરો.

HINDI

यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, कृपया अपने सदस्य आईडी कार्ड पर दिये सदस्य सेवा नंबर पर कॉल करें।

ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

JAPANESE

ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、お持ちの会員IDカードにある、会員サービスの電話番号までお問い合わせ下さい。

KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

Notice of Non-Discrimination

CareSource

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 call the member services number on your member ID card.

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

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

CivilRightsCoordinator@CareSource.com

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

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

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

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

CareSource®

Member Services

1-833-230-2020 (TTY: 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/DSNP

Y0119_OH-DSNP-M-597400_M Accepted