CommuniCare ADVANTAGE

2024 Summary of Benefits

Medicare Advantage HMO

Chronic Condition Special Needs Plan

Look inside to learn more about the health services and drug coverage CommuniCare Advantage provides.

Toll-Free (855) 969-5869, TTY 711
8:00 a.m. – 8:00 p.m. seven days a week October 1st through March 31st (8:00 a.m. – 8:00 p.m. Monday through Friday April 1st through September 30th)

www.communicare-advantage.com

H3727_CSNP-2024-SB_M

Summary of Benefits — January 1, 2024, through December 31, 2024

About Our Plan

CommuniCare Advantage Chronic Condition Special Needs Plan (CSNP) is a Medicare Advantage HMO plan with a Medicare contract. It is insured through OH CHS SNP, Inc.
Enrollment in the plan depends on contract renewal. The CommuniCare Advantage CSNP has been approved by the Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) through 2024 based on a review of CommuniCare Advantage's Model of Care.

To join our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, be a United States citizen (or lawfully present in the United States), live within our service area, and have at least one of the following chronic conditions: diabetes, chronic heart failure, or cardiovascular disease. Our service area includes these states and counties:

- Indiana: Hamilton, Hancock, Hendricks, Johnson, and Marion Counties
- Maryland: Baltimore City, Baltimore County, and Anne Arundel Counties
- Ohio: Butler, Cuyahoga, Hamilton, Lorain, and Montgomery Counties

CommuniCare Advantage CSNP has a network of doctors, hospitals, pharmacies, and other types of providers. Except in emergency situations, if you use providers or pharmacies that are not part of our network, we may not pay for these services. If you are new to our plan, we will cover important care from out of network providers for a limited time (no more than 90 days) until your services can be moved to an in-network doctor or provider. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

To find out more about which providers are in our network, please go to www.communicare-advantage.com. You will also find a link to our Drug List to see what drugs are covered, any restrictions, and your options for purchasing.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. You can view it online at 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/TDD users should call 1-877-486-2048. This information is available in other formats and languages.

The benefit information provided is a summary of what we cover and what you pay for the services or drugs. It does not list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.communicare-advantage.com or you can call Member Services at 1-855-969-5861 (TTY/TDD 711) for help. Our hours are 8:00 a.m. – 8:00 p.m. seven days a week October 1st through March 31st (8:00 a.m. – 8:00 p.m. Monday through Friday April 1st through September 30th).

Premiums and Benefits	CommuniCare Advantage CSNP
Monthly Plan Premium	Part C: $0 Part D: $0 You must continue to pay your Medicare Part B premium
Deductible	Part B deductible: $0 Part C deductible: $0 Part D deductible: $545 except for insulin furnished through an item of durable medical equipment
Maximum Out-of-Pocket Responsibility (does not include out of network or Part D prescription drugs)	$8,850
Inpatient Hospital (including Mental Health Inpatient)	Per benefit period: You pay $375 per day for days 1-5 You pay nothing per day for days 6-90 You pay $788 per day for up to 60 lifetime reserve days Once lifetime reserve days are exhausted you pay all costs For Mental Health Inpatient: You pay $325 per day for days 1-5 You pay nothing per day for days 6-90 You pay $788 per day for up to 60 lifetime reserve days Once lifetime reserve days are exhausted you pay all costs Prior Authorization is required for all inpatient stays
Outpatient Hospital	You pay 20% coinsurance Prior authorization is required
Ambulatory Surgical Center (ASC)	You pay 10% coinsurance Prior authorization is required
Doctor Visits • Primary Care Provider (PCP) • Specialists	You pay $0 for PCP visits You pay $50 per visit for most specialists Exceptions: You pay $15 for each chiropractor visit You pay $10 for each visit to a cardiologist or endocrinologist
Preventive Care (flu vaccine, COVID vaccine, diabetic screenings, mammograms, colorectal cancer screenings, and other preventive services)	You pay $0 for Medicare-covered zero-dollar preventive care services like those listed here. Other preventive services are available, some with a cost.
Emergency Care	You pay $90 for each visit
Urgently Needed Services	You pay $40 for each visit

Diagnostic Services/Labs/Imaging • Diagnostic tests and procedures • Lab services • Diagnostic radiology (e.g. MRI, CT scans) • Outpatient X-rays	You pay 20% coinsurance for diagnostic procedures and tests including radiology and x-rays You pay $3.00 for labs in a doctor's office or free standing lab, and $20 for lab services in an outpatient hospital setting Prior authorization is required for most diagnostic tests and radiology
Hearing Services • Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment • Extra benefits for routine hearing care, as outlined in the Extra Benefits section	You pay $0 for routine hearing exams You pay $0 for extra hearing benefits up to an annual benefit limit of $1,800
Dental services • Preventive services and comprehensive dental care • Extra benefits for routine hearing care, as outlined in the Extra Benefits section	You pay $0 for preventive and comprehensive dental services, up to an annual benefit limit of $1,000
Vision Services • Routine Eye Exam • Eyewear	You pay $0 per visit for Medicare-covered eye exams. You pay $0 for routine vision services up to an annual benefit limit of $250
Mental Health Services • Outpatient group therapy/individual therapy • Outpatient partial hospitalization	You pay $35 per visit for group and individual therapy You pay $55 per day for partial hospitalization Prior authorization is required
Skilled Nursing Facility	You pay $0 for days 1-20 You pay $194.50 for days 21-100 You pay all costs for days 101 and beyond
Physical Therapy, Occupational Therapy and Speech Therapy	You pay $40 per visit Prior authorization is required
Ambulance (Ground and Air)	You pay 20% coinsurance for each one way trip.
Transportation (Non-emergent)	24 one-way trips per year
Medicare Part B Drugs	You pay $35 copayment for Part B Insulin drugs You pay no more than a 20% coinsurance for all other Part B drugs Prior authorization is required for drugs over $250

Prescription Drugs

If you do not qualify for a Low-Income Subsidy (LIS), you pay the Medicare Part D cost share outlined in the Evidence of Coverage. If you do qualify for the LIS, your costs may be lower.

About our drug coverage:

- We offer five tiers of drug coverage: (1) preferred generic, (2) generic, (3) preferred brand, (4) non-preferred drug, and (5) specialty drugs.
- In the catastrophic phase the plan pays the full cost for your covered Part D drugs. You pay nothing.
- We cover most Part D vaccines at no cost to you, even if you haven't paid your deductible.
- You won't pay more than $35 for a one-month supply of each insulin product.

Outpatient Prescription Drugs	
Deductible	Tiers 1, 2, 3: $0 Tiers 4, 5: $545
Initial Coverage for 30-day supply • Tier 1: Preferred Generic • Tier 2: Generic • Tier 3: Preferred Brand • Tier 4: Non-Preferred Drug • Tier 5: Specialty	You pay per drug, per month: $6 retail/$5 mail order $17 retail/$15 mail order $45 retail/$40 mail order $92 retail/$90 mail order 25% of the cost of the drug, plus dispensing fee
Coverage Gap (after your total drug costs reach $5,030)	You pay 25%
Catastrophic Coverage (after you or others on your behalf pay $8,000)	The plan pays the full cost for your covered Part D drugs. You pay nothing.

Extra Benefits

The following benefits are available as applicable with the in-network costs as noted. There is no additional premium for access to these benefits.

Benefit	Description	In-Network Costs
Hearing Services	Up to $1,800 per year for routine hearing exams, hearing aids, and hearing aid services, including evaluation and fitting, repair, and batteries.	$0
Dental Services	Comprehensive dental services including x-rays, cleanings, oral exams, extractions, and other services. Annual benefit amount is $1,000.	$0
Vision Services	Up to $250 for routine vision screening exams, contacts, or glasses to address normal changes with aging.	$0
Meal Service after Hospitalization	After hospitalization, you can receive three meals per day for seven days (requires prior authorization). This benefit is limited to one occurrence per year.	$0
Non-Emergent Transportation	24 one-way trips per to medical appointments. Authorization is required.	$0