CommuniCare ADVANTAGE

2024 Summary of Benefits

Medicare Advantage HMO

Institutional Special Needs Plan

OHIO

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

Toll-Free (855) 969-5861, 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_ISNP-2024-SB-Ohio_M

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

About Our Plan

CommuniCare Advantage Institutional Special Needs Plan (ISNP) 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 ISNP 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 in a participating facility within our service area, and have lived in a nursing facility or be expected to reside in a nursing facility for 90 or more days.

Our service area includes these counties in Ohio: Butler, Clark, Cuyahoga, Geauga, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Stark, Summit, Trumbull, and Williams.

Participating facilities are listed on our website, www.communicare-advantage.com. CommuniCare Advantage ISNP 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 here 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 ISNP
Monthly Plan Premium	Part C: $0 Part D: $40.90 You must continue to pay your Medicare Part B premium.
Deductible	Part B deductible: $240 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)	You pay a deductible of $1,632 per benefit period You pay nothing per day for days 1-60 You pay $408 per day for days 61-90 You pay $816 per day after day 90 of each benefit period, up to a maximum of 60 days over your lifetime Prior Authorization is required for all inpatient stays
Outpatient Hospital	You pay 20% coinsurance Prior authorization is required for all surgical procedures and many diagnostic procedures
Ambulatory Surgical Center (ASC)	You pay 20% coinsurance Prior authorization is required
Doctor Visits • Primary Care Provider (PCP) • Specialists	You pay 20% coinsurance per visit
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 $100 for each visit
Urgently Needed Services	You pay 20% coinsurance for each visit Maximum per visit $55
Diagnostic Services/Labs/Imaging • Diagnostic tests and procedures • Lab services • Diagnostic radiology (e.g. MRI, CT scans) • Outpatient X-rays	Diagnostic radiology, tests and procedures and x-rays: you pay 20% coinsurance Lab services: you pay 20% coinsurance Prior authorization is required for most diagnostic tests and radiology

Premiums and Benefits	CommuniCare Advantage ISNP
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 Medicare-covered hearing services performed by your PCP. You pay $0 for extra hearing benefits up to an annual benefit limit of $1,500
Dental services Further details are outlined in the Extra Benefits section	You pay $0 for preventive and comprehensive dental services up to an annual benefit of $2,000
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 $350
Mental Health Services • Outpatient Individual or Group Therapy Visit	You pay 20% coinsurance per visit
Skilled Nursing Facility (SNF)	You pay nothing per day for days 1-100 You pay all costs for days 101 and beyond Prior Authorization is required for all out-of-network skilled nursing stays
Physical Therapy, Occupation Therapy and Speech Therapy	You pay $0 per visit Prior authorization is required
Ambulance **(Ground and Air)**	You pay 20% coinsurance for each one way trip.
Transportation (Non-emergent)	36 one-way trips per year
Medicare Part B Drugs	You pay $35 copayment for Part B Insulin drugs You pay 0-20% 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 a one-tier drug coverage plan.
- 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, even if you haven't paid your deductible.

Outpatient Prescription Drugs for Retail, Mail Order, and LTC Pharmacy	
Deductible	$545
Initial Coverage for 30-day supply	You pay 25%
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
Over-the-Counter Comfort Care Items	Members may select from a catalog of items such as shampoo, lotion, lip balm, socks and other items. Benefit is $155 per quarter. Unused amounts do not roll over to the next quarter	$0
Hearing Services	Up to a $1,500 benefit 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 amounts for 2024 is $2,000	$0
Vision Services	Up to $350 for routine vision screening exams, contacts, or glasses to address normal changes with aging	$0
Non-Emergent Transportation	36 one-way trips per year to medical appointments. Authorization is required.	$0
Podiatry Services (Routine Foot Care)	12 visits per year	$0