CommuniCare ADVANTAGE

2024 Summary of Benefits

Medicare Advantage Sapphire HMO

OHIO

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

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

About Our Plan

CommuniCare Advantage Sapphire 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 approval.

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), and live within our service area. In Ohio this service area includes Butler, Hamilton, and Montgomery Counties.

CommuniCare Advantage Sapphire ("Sapphire") 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 Sapphire
Monthly Plan Premium	Part C: $0 Part D: $20 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 (does not include out of network or Part D prescription drugs)	$8,850
Inpatient Hospital (including Mental Health Inpatient)	Per benefit period: You pay $295 per day for days 1-5 You pay $0 per day for days 6-90 You pay $788 per day for days 91 and beyond, up to a maximum of 60 lifetime reserve days. Authorization is required for all inpatient stays.
Outpatient Hospital	You pay up to $295 copayment per visit. Prior authorization is required for all surgical procedures.
Ambulatory Surgical Center (ASC)	You pay up to a $195 copayment Prior authorization is required
Doctor Visits • Primary Care Provider (PCP) • Specialists	You pay $0 for PCP visits You pay $25 per visit for most other specialists Exception: You pay $15 per visit for a chiropractor
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 a $30 copayment for diagnostic procedures and tests. You pay $0 for labs. You pay up to $110 copayment for diagnostic radiology. You pay $15 copayment for x-rays. Prior authorization is required for most diagnostic tests and radiology.

Premiums and Benefits	CommuniCare Advantage Sapphire
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 a benefit limit of $800 every 3 years.
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 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 $300
Mental Health Services • Outpatient mental health specialty services: group therapy • Outpatient mental health specialty services: individual therapy • Outpatient partial hospitalization	You pay $15 for group therapy You pay $25 for 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 $196 per day for days 21-42 You pay $0 for days 43-100 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 $220 copayment per trip for ground or air ambulance Prior authorization is required for non-emergent ambulance.
Transportation (Non-emergent)	24 one-way trips per year
Medicare Part B Drugs	You pay $35 copayment for Part B Insulin drugs You pay up to 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 drugs, 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.
- With our plan, you will pay no more than $35 for a 1-month supply of each covered 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: $3 $8 $45 $95 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
Hearing Services	$800 benefit for routine hearing exams, hearing aids, and hearing aid services, including evaluation and fittings, repair, and batteries every 3 years.	$0
Dental Services	$1,000 benefit for routine, preventive, and comprehensive dental services including x-rays, cleanings, oral exams, extractions, and other services.	$0
Vision Services	$300 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 annually. Requires prior authorization.	$0
Fitness	Membership with Silver Sneakers	$0
Over-the-Counter (OTC)	$50 benefit every quarter for members to select from a catalog of over the counter items. Unused amounts do not roll over to the following quarter.	$0
Worldwide Emergency Services	Up to a maximum of $50,000 coverage for emergency and urgent healthcare services rendered outside of the United States or its territories.	$95 copayment
Podiatry Services (Routine Foot Care)	6 visits annually	You pay a $25 copayment per visit
Non-Emergent Transportation Services	24 one-way trips to medical appointments	$0