CommuniCare ADVANTAGE

2023 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

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Summary of Benefits — January 1, 2023, through December 31, 2023

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. D/B/A CommuniCare Advantage. 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 2023 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 C-SNP 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 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 1-855-969-5869 (TTY 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). When you enroll in the plan, you will get information that tells you where you can go online to view your EOC.

Premiums and Benefits	CommuniCare Advantage Chronic Condition Special Needs Plan
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	$0
Maximum Out-of-Pocket Responsibility (does not include out of network or Part D prescription drugs)	$8,300
Inpatient Hospital Mental Health Inpatient Hospital	You pay $375 per day for days 1-5 You pay nothing per day for days 6-90 You pay $788 per day for days 91 and beyond You pay $325 per day for days 1-5 You pay nothing per day for days 6-90 You pay $788 per day for days 91 and beyond Authorization is required for all inpatient stays.
Outpatient Hospital	You pay 20% coinsurance. Prior authorization is required for all surgical procedures.
Ambulatory Surgical Center (ASC)	You pay 10% coinsurance. Prior authorization is required for all surgical procedures.
Doctor Visits • Primary Care Provider (PCP) • Specialists	 You pay $0 for PCP visits You pay $10 per visit for cardiologists and endocrinologists You pay $10 per visit for a podiatrist You pay $50 per visit for most other specialists
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) • X-rays	 You pay 20% coinsurance You pay $3 for lab tests in a doctor's office or freestanding lab and $20 in the outpatient department of a hospital You pay 20% coinsurance You pay 20% coinsurance

Premiums and Benefits	CommuniCare Advantage Chronic Condition Special Needs Plan
	**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 20% coinsurance $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*	$0 for preventive and comprehensive dental services, up to an annual benefit limit of $1,250
Vision Services • Exams to diagnose and treat medical conditions such as glaucoma or diabetic retinopathy • Our Plan offers extra benefits for routine vision care, as outlined in the Extra Benefits section	You pay $50 per visit 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 • Psychiatrist visit	You pay $35 per visit You pay $55 per day. Prior authorization is required. You pay $40 per visit
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+
Physical Therapy	You pay $40 per visit. Prior authorization is required.
Ambulance	You pay 20% coinsurance
Transportation (Non-emergent)	Not covered
Medicare Part B Drugs	You pay 20% coinsurance for all 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) brand, and (5) specialty drugs.
- With our plan, you will pay no more than $35 for a 1-month supply of each covered insulin product.
- We cover most Part D vaccines at no cost to you, even if you haven't paid your deductible.
- In the catastrophic phase, you will pay 5% of the cost of the drug, or $4.15 copay for generic drugs, or $10.35 copay for brand name drugs, whichever is MORE.

Outpatient Prescription Drugs	
Deductible	Tiers 1, 2, 3: $0 Tiers 4, 5: $505
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: $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 $4,660)	You pay 25%
Catastrophic Coverage (after you or others on your behalf pay $7,400) • Generic • Brand	You pay per drug: $4.15 or 5% (whichever costs more) $10.35 or 5% (whichever costs more)

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
Diabetic Supplies	Routine diabetic supplies such as syringes and test strips	$0
Hearing Services	Up to a $1500 benefit for routine hearing exams, hearing aids, and hearing aid services, including evaluation and fitting, repair, and batteries	$0
Dental Services	Up to a $1,250 benefit for routine, preventive, and comprehensive dental services including x-rays, cleanings, oral exams, extractions, and other services	$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)	$0