
**2025 Summary of Benefits**
Clear Spring Health Community Advantage Plan (HMO) H3071-002
Clear Spring Health Essential (HMO) H5454-001
Clear Spring Health Essential (HMO) H5454-002

Y0145_OP 181-091124_M

**SUMMARY OF BENEFITS**
2025

This is a summary of health and drug services covered by Clear Spring Health Essential (HMO) and Clear Spring Health Community Advantage Plan (HMO) from January 1, 2025 – December 31, 2025.

Clear Spring Heath has a contract with Medicare to offer HMO, PPO, and PDP Plans. Enrollment in these plans is dependent on annual contract renewal with the federal government.

list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please visit www.clearspringhealthcare.com for the 2025 "Evidence of Coverage," or call 1-877-364-4566 to request a copy of the Evidence of Coverage to be mailed to you. TTY users should call 711. The Evidence of Coverage will be available on our website by no later than October 15, 2024.

To join Clear Spring Health Community Advantage Plan (HMO) or Clear Spring Health Essential (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare B, and live in our service area. Our service area includes the following counties in Illinois:

For plan **H3071-002**: Boone, Cook, DuPage, Kane, McHenry, Ogle, Will, Winnebago.

For plan **H5454-001**: Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson, Winnebago.

For plan **H5454-002**: Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will.

If you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4277). TTY users should call 1-877-486-2048.

Clear Spring Health

## Call us or go online for more information

**Not a member yet? Call 1-877-248-6622 (TTY: 711)**
From October 1st – March 31st, you can call us 7 days a week from 8:00am to 8:00pm. From April 1st – September 30th, you can call us Monday through Friday from 8:00am – 8:00pm.

**Already a member? Call 1-877-364-4566 (TTY:711)**
From October 1st – March 31st, you can call us 7 days a week from 8:00am to 8:00pm. From April 1st – September 30th, you can call us Monday through Friday from 8:00am – 8:00pm.

**Website:** Clearspringhealthcare.com

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.clearspringhealthcare.com** or call **1-877-364-4566 (TTY: 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Clear Spring Health offers a pharmacy network with preferred cost sharing at select pharmacies. You may pay more at other pharmacies. The Preferred Pharmacy Network is a select network of national and local independent pharmacies designed to help save you money on your prescriptions. You may choose non-preferred pharmacies to fill prescriptions, but your costs may be higher. Our pharmacy network may change at any time. You will receive notice when necessary.
- Benefits with a (!) indicates a prior authorization may be required.

## Understanding Important Rules

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/co-insurance may change January 1, 2026.

**SUMMARY OF BENEFITS**
2025

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Monthly Plan Premium** | **$0**<br>You must continue to pay your Medicare Part B premium. | | |
| **Deductible (Part C - Medical)** | **$0** | | |
| **Maximum Out-of-Pocket** | **$2,950** | **$2,900** | |
| **Inpatient Hospital Coverage** - Acute (!) | **$220 copay** per day for days 1-7; **$0 copay** per day for days 8-90 | **$225 copay** per day for days 1-8; **$0 copay** per day for days 9-90 | |
| **Inpatient Hospital Coverage –** Psychiatric (!) | **$220 copay** per day for days 1-7; **$0 copay** per day for days 8-90 | **$225 copay** per day for days 1-8; **$0 copay** per day for days 9-90 | |
| **Outpatient Hospital Coverage (!)** | **$225 copay** | **$30 copayment** for some skin tag removals performed at a dermatologist's office.<br><br>**$200.00 copayment** for all other services.<br><br>Prior authorization required for Medicare covered Observation Services after 24 hours. | |
| **Ambulatory Surgical Center (ASC) Services (!)** | **$175 copay** | **$30 copayment** for some skin tag removals performed at a dermatologist's office.<br><br>**$150 copayment** for all other services. | |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Doctor Visits** (Primary Care Providers and Specialists) (!) | **Primary Care: $0 copay**<br>Visits to assigned PCP's don't need prior authorization.<br><br>**Specialist: $0 copay**<br>Office visits to in-network specialists for HMO members don't require prior authorization. Visits to out-of-network specialists require prior authorization. Some procedures done in specialists' office may need prior approval for both in and out of network. | **Primary Care: $0 copay**<br>Visits to assigned PCP's don't need prior authorization.<br><br>**Specialist: $0 copay** for Endocrinologist. **$35 copay** for all other Specialists. Office visits to in-network specialists for HMO members don't require prior authorization. Visits to out-of-network specialists require prior authorization. Some procedures done in specialists' office may need prior approval for both in and out of network. | |
| **Preventative Care** (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit) | **$0 copay for preventive care.** | | |
| **Emergency Care** | **$90 copay**<br><br>ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. | | |
| **Urgently Needed Services** | **$35 copay**<br><br>Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. | | |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Diagnostic Services/ Labs/Imaging (!)**<br>Diagnostic tests and procedures<br>Lab Services<br>Diagnostic radiology<br>Outpatient x-rays | **DIAGNOSTIC TESTS AND PROCEDURES:**<br>**$0 copay**<br><br>**LAB SERVICES:**<br>**$0 copay**<br><br>**DIAGNOSTIC RADIOLOGY:**<br>**$0 copayment** for some diagnostic ultrasound and diagnostic bone density imaging.<br>**$100 copayment** for all other Diagnostic Radiological Services (e.g., CT, MRI).<br><br>**X-RAYS:**<br>**$0 copay** for x-ray services if performed at a PCP office. **$100 copay** for x-ray services if performed at a specialist or facility. | **DIAGNOSTIC TESTS AND PROCEDURES:**<br>**$0 copay**<br><br>**LAB SERVICES:**<br>**$0 copay**<br><br>**DIAGNOSTIC RADIOLOGY:**<br>**$20 copayment** for diagnostic ultrasound and diagnostic bone density imaging.<br>**$175 copayment** for all other Diagnostic Radiological Services (e.g., CT, MRI).<br><br>**X-RAYS: $4 copay** | |
| **Hearing Services**<br>Routine Hearing Exam<br>Hearing Aids | **MEDICARE COVERED HEARING EXAM**<br>**$30 copay** | | |
| | **ROUTINE HEARING EXAM**<br>1 exam every year. **$0 copay.**<br><br>**HEARING AIDS**<br>**$500 maximum** plan coverage amount every year (per ear) for prescription hearing aids. Hearing aids must be purchased through NationsHearing to access the benefit. | | |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Dental Services** | **MEDICARE COVERED HEARING EXAM**<br>**$30 copay** | | |
| | **NON-MEDICARE COVERED DENTAL SERVICES**<br><br>**Preventive Services: $0 copay**<br><br>**Comprehensive Services: $0 copay**<br><br>**$3,000 maximum** plan coverage amount every year for non-Medicare-covered comprehensive dental services.<br><br>Refer to the Evidence of Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered. | **NON-MEDICARE COVERED DENTAL SERVICES:**<br><br>**Preventive Services: $0 copay**<br><br>**Comprehensive Services: $0 copay**<br><br>**$1,500 maximum** plan coverage amount every year for non-Medicare covered comprehensive dental services.<br><br>Refer to the Evidence of Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered. | |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Vision Services** | **MEDICARE COVERED EYE EXAM SERVICES**<br>**$30 copay** | | |
| | **ROUTINE EYE EXAM:**<br>1 exam every year<br><br>**$0 copay** for routine eye exam.<br><br>**$300 maximum** plan coverage amount every year for all non-Medicare-covered eyewear. | **ROUTINE EYE EXAM:**<br>1 exam every year<br><br>**$0 copay** for routine eye exam.<br><br>**$200 maximum** plan coverage amount every year for all non-Medicare-covered eyewear. | |
| **Mental Health Services** | **MENTAL HEALTH (INDIVIDUAL SESSIONS):**<br>**$30 copay**<br><br>**MENTAL HEALTH (GROUP SESSIONS):**<br>**$30 copay** | **MENTAL HEALTH (INDIVIDUAL SESSIONS):**<br>**$30 copay**<br><br>**MENTAL HEALTH (GROUP SESSIONS):**<br>**$30 copay** | |
| **Skilled Nursing Facility (!)** | **$0 copay** per day for days 1-20; **$178 copay** per day for days 21-100 | **$20 copay** per day for days 1-20;<br>**$178 copay** per day for days 21-100 | |
| **Physical & Speech Therapy (!)** | **$20 copay** | **$30 copay** | |
| **Ambulance (!)** | **GROUND:**<br>**$200 copay**<br>Prior authorization is needed for non-emergency ambulance rides.<br><br>**AIR:**<br>**20% of the total cost** | **GROUND:**<br>**$225 copay**<br>Prior authorization is needed for non-emergency ambulance rides.<br><br>**AIR:**<br>**$225 copay** | |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Transportation(!)** | 12 one-way trips every year to plan-approved health-related locations. Transportation administered and managed by our partner Kaizen Health. Round trips greater than 25 miles may require prior authorization. | | |
| **Medicare Part B Drugs (!)** | **0% to 20% of the total cost**<br><br>**The 0%** coinsurance applies to drugs covered under the Inflation Reduction Act.<br><br>**The 20% cost-sharing** applies to all other Medicare Part B drugs not covered under the Inflation Reduction Act. For a list of drugs covered at 0% cost-sharing under the Inflation Reduction Act, visit https://www.cms.gov/files/document/reduced-coinsurance-certain-part- b-rebat-able-drugs-july-1-september-30-2024.pdf | | |
| **Grocery Benefit** | **$100 per month toward healthy food and produce.**<br><br>Benefit administered by NationsBenefits on a prefunded Mastercard, to be used as credit online or at participating retailers. Amount does not carry over to next month.<br><br>A health risk assessment (HRA) must be submitted. Must have a qualifying chronic illness that may include cancer, dementia, diabetes, and autoimmune disorders.<br><br>*Eligibility for these benefits cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us. | | |
| **Over-the-Counter Benefit** | **$65 maximum** plan coverage amount every month for OTC items.<br><br>Unused portion does not carry over to the next period. | **$55 maximum** plan coverage amount every month for OTC items.<br><br>Unused portion does not carry over to the next period. | **$60 maximum** plan coverage amount every month for OTC items.<br><br>Unused portion does not carry over to the next period. |

Clear Spring Health

| | COMMUNITY ADVANTAGE (HMO) (H3071-002) | ESSENTIAL (HMO) (H5454-001) | ESSENTIAL (HMO) (H5454-002) |
|---|---|---|---|
| **Utility Benefit** | **$50 a month** toward approved utility expenses - water, electric, phone (landline and/or cell phone), and Internet.<br><br>A copy of the bill with your name and address must be submitted to the plan monthly for reimbursement. Unused portion does not rollover to next period.<br><br>A health risk assessment (HRA) must be submitted. Must have a qualifying chronic illness that may include cancer, dementia, diabetes, and autoimmune disorders.<br><br>*Eligibility for these benefits cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us. | | |
| **Better Health 4 You (Rewards & Incentives)** | The Better Health 4 You program is offered to members who are enrolled in the Community Advantage Plan HMO H3071-002 at no cost. Get rewarded for actively participating in health screenings. | Not Covered | |
| **SilverSneakers** | SilverSneakers membership is available at no cost while a member of the plan. Any services not included in a basic membership may require additional fees. Access to over 15,000 locations nationwide. Members get access to SilverSneakers LIVE online classes, On-Demand videos, and thousands of fitness locations and classes. | | |

**SUMMARY OF BENEFITS**
2025

Clear Spring Health

| | PRESCRIPTION DRUGS<br>CLEAR SPRING HEALTH COMMUNITY ADVANTAGE PLAN (HMO)<br>H3071-002 | | | | |
|---|---|---|---|---|---|
| **Deductible** | **$0** | | | | |
| **Maximum out of Pocket** | **$2,000 OUT-OF-POCKET MAXIMUM**<br>Your total out-of-pocket costs for prescription drugs will be capped at $2,000 per year. You will pay the below cost-shares until you reach the maximum out-of-pocket. Once you reach this cap, you will not have to pay any more out-of-pocket costs for your prescription drugs for the remainder of the year. | | | | |
| **Pharmacy Type** | **Preferred Retail 30-day supply** | **Non-Preferred Retail 30-day supply** | **Preferred Retail 90-day supply** | **Non-Preferred Retail 90-day supply** | **Preferred Mail Order 30-day supply** |
| **Tier 1: Preferred Generic** | **$0 copay** | **$5 copay** | **$0 copay** | **$5 copay** | **$0 copay** |
| **Tier 2: Generic** | **$0 copay** | **$17 copay** | **$0 copay** | **$10 copay** | **$0 copay** |
| **Tier 3: Preferred Brand** | **$42 copay** | **$47 copay** | **$105 copay** | **$117.50 copay** | **$42 copay** |
| **Tier 4: Non-Preferred Drug** | **$95 copay** | **$100 copay** | **$237.50 copay** | **$250 copay** | **$95 copay** |
| **Tier 5: Specialty** | **33% of the total cost** | **33% of the total cost** | **A long-term supply is not available for drugs in Tier 5.** | **A long-term supply is not available for drugs in Tier 5.** | **33% of the total cost** |

Clear Spring Health

| | **PRESCRIPTION DRUGS**<br>CLEAR SPRING HEALTH ESSENTIAL (HMO)<br>**H5454-001** | | | | |
|---|---|---|---|---|---|
| **Deductible** | **$0** | | | | |
| **Maximum out of Pocket** | **$2,000 OUT-OF-POCKET MAXIMUM**<br>Your total out-of-pocket costs for prescription drugs will be capped at $2,000 per year. You will pay the below cost-shares until you reach the maximum out-of-pocket. Once you reach this cap, you will not have to pay any more out-of-pocket costs for your prescription drugs for the remainder of the year. | | | | |
| **Pharmacy Type** | **Preferred Retail 30-day supply** | **Non-Preferred Retail 30-day supply** | **Preferred Retail 90-day supply** | **Non-Preferred Retail 90-day supply** | **Preferred Mail Order 30-day supply** |
| **Tier 1: Preferred Generic** | **$0 copay** | **$10 copay** | **$0 copay** | **$30 copay** | **$0 copay** |
| **Tier 2: Generic** | **$0 copay** | **$19 copay** | **$0 copay** | **$57 copay** | **$0 copay** |
| **Tier 3: Preferred Brand** | **$42 copay** | **$47 copay** | **$126 copay** | **$141 copay** | **$42 copay** |
| **Tier 4: Non-Preferred Drug** | **$95 copay** | **$100 copay** | **$285 copay** | **$300 copay** | **$95 copay** |
| **Tier 5: Specialty** | **33% of the total cost** | **33% of the total cost** | **A long-term supply is not available for drugs in Tier 5.** | **A long-term supply is not available for drugs in Tier 5.** | **33% of the total cost** |

Clear Spring Health

| | **PRESCRIPTION DRUGS**<br>CLEAR SPRING HEALTH ESSENTIAL (HMO)<br>**H5454-002** | | | | |
|---|---|---|---|---|---|
| **Deductible** | **$0** | | | | |
| **Maximum out of Pocket** | **$2,000 OUT-OF-POCKET MAXIMUM**<br>Your total out-of-pocket costs for prescription drugs will be capped at $2,000 per year. You will pay the below cost-shares until you reach the maximum out-of-pocket. Once you reach this cap, you will not have to pay any more out-of-pocket costs for your prescription drugs for the remainder of the year. | | | | |
| **Pharmacy Type** | **Preferred Retail 30-day supply** | **Non-Preferred Retail 30-day supply** | **Preferred Retail 90-day supply** | **Non-Preferred Retail 90-day supply** | **Preferred Mail Order 30-day supply** |
| **Tier 1: Preferred Generic** | **$0 copay** | **$10 copay** | **$0 copay** | **$30 copay** | **$0 copay** |
| **Tier 2: Generic** | **$0 copay** | **$19 copay** | **$0 copay** | **$57 copay** | **$0 copay** |
| **Tier 3: Preferred Brand** | **$42 copay** | **$47 copay** | **$126 copay** | **$141 copay** | **$42 copay** |
| **Tier 4: Non-Preferred Drug** | **$95 copay** | **$100 copay** | **$285 copay** | **$300 copay** | **$95 copay** |
| **Tier 5: Specialty** | **33% of the total cost** | **33% of the total cost** | **A long-term supply is not available for drugs in Tier 5.** | **A long-term supply is not available for drugs in Tier 5.** | **33% of the total cost** |

If you receive "Extra Help" for your drugs, you will pay the following prior to reaching your annual $2,000 out-of-pocket limit. You will pay one of the following depending on your level of "Extra Help":

Å$4.90 for generic/preferred multi-source drug or biosimilar; $12.15 for any other drug; OR
Å$1.60 for generic/preferred multi-source drug or biosimilar; $4.80 for any other drug; OR
Å$0 for all drugs

After reaching your annal $2,000 out-of-pocket limit, you will pay $0 for the remainder of the calendar year, regardless of the level of "Extra Help" your receive. Additional information will be available on your LIS rider.

**Important Message About What You Pay for Insulin –** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on at any in-network pharmacy.

**Important Message About What You Pay for Vaccines -** Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1-800-325-0778. For more information on additional pharmacy specific cost-share and the drug coverage stages, please call our Customer Service department, or access our "Evidence of Coverage" online or request one by mail.