

## Clear Spring Health Essential HMO

H5454, Plan 001 and H5454, Plan 002

January 1, 2019 - December 31, 2019

**Clear Spring Health** is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage.” You can obtain a copy of our Evidence of Coverage by calling us at 877-384-1241, TTY: 711 or visiting our website at [www.clearspringhealthcare.com](http://www.clearspringhealthcare.com).

To join **Clear Spring Health** (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Illinois: Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson, Winnebago, Cook DuPage, Kane, Kankakee, La Salle, McHenry and Will.

Except in emergency situations, 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](http://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 document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-877-384-1241 (TTY:711) or visit us at [www.clearspringhealthcare.com](http://www.clearspringhealthcare.com). Our call center is open from 8:00 am to 8:00 pm, Monday through Friday from April 1 through September 30 and 8:00 am to 8:00 pm, Monday through Sunday from October 1 through March 31. You may leave a voicemail Saturday, Sunday and Federal Holidays.

**ATTENTION:** If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-384-1241 (TTY:711).

Clear Spring Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Premiums and Benefits	Clear Spring Health Essential HMO
<b>Monthly Plan Premium</b>	You pay \$0 You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	No deductible
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	You pay no more than \$3,400 annually Includes copays and other costs for medical services for the year.
<b>Inpatient Hospital</b>	You pay \$225 per day for days 1 through 8 You pay nothing per day for days 9 through 90 Prior authorization is required. Referral required.
<b>Outpatient Hospital</b>	You pay \$200. Prior Authorization is required for outpatient services Referral required.

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<b>Doctor Visits</b> <ul style="list-style-type: none"> <li>Primary</li> <li>Specialists</li> </ul>	You pay nothing You pay \$30 Prior authorization is required for specialist visits. Referral required.
<b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)	You pay nothing. Authorization is required for preventive care. Referral required. Other preventive services are available. There are some covered services that have a cost.
<b>Emergency Care</b>	You pay \$120 per visit.
<b>Urgently Needed Services</b>	You pay \$35 per visit

**DIAGNOSTIC SERVICES/LABS/IMAGING**

<b>Diagnostic Services/Labs/Imaging</b> <ul style="list-style-type: none"> <li>Diagnostic tests and procedures</li> </ul>	You pay \$2. Referral required.
<ul style="list-style-type: none"> <li>Lab services</li> </ul>	You pay \$2. Referral required
<ul style="list-style-type: none"> <li>MRI, CAT Scan</li> </ul>	You pay 20% of the cost . Referral required
<ul style="list-style-type: none"> <li>X-Rays</li> </ul>	You pay \$4 Prior authorization is required for some services. Referral required

**HEARING SERVICES**

<b>Supplemental Benefits</b> <ul style="list-style-type: none"> <li>Routine hearing exam</li> <li>Hearing aid</li> </ul>	You pay \$5, one routine hearing exam allowed annually. Referral required You pay \$380 per hearing aid (all types) Authorization is required for hearing exams and hearing aids. Referral required
<b>Medicare Covered Benefits</b> <ul style="list-style-type: none"> <li>Hearing Exams</li> </ul>	You pay \$5 per visit. Authorization is required. Referral required

**DENTAL SERVICES**

<b>Preventive—Supplemental Benefits</b> <ul style="list-style-type: none"> <li>Oral exam &amp; Cleaning</li> </ul>	Not covered
<b>Comprehensive</b>	Medicare covered benefits only. You pay 20%. Prior authorization is required. Referral required

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Premiums and Benefits		Clear Spring Health Essential HMO
<b>VISION SERVICES</b>		
<b>Supplemental Benefits</b> <ul style="list-style-type: none"> <li>Routine eye exam</li> <li>Eyeglasses (frames and lenses)</li> </ul>	You pay nothing, 1 routine eye exam allowed annually. Referral required \$105 every two years towards purchase Authorization is required for eye exams and eyeglasses. Referral required	
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>Outpatient group therapy/ individual therapy visit</li> <li>Inpatient services</li> </ul>	You pay \$30. Authorization is required for mental health services. Referral required  You pay \$225 per day for days 1 through 8. You pay nothing per day for days 9 through 90. Prior authorization is required. Referral required	
<b>Skilled Nursing Facility</b>	You pay nothing for days 1 through 20 You pay \$172 per day for days 21 through 42 You pay nothing for days 43 through 100 Prior Authorization is required for Skilled Nursing Facility. Referral required	
<b>Physical Therapy</b>	You pay \$30. Prior Authorization is required. Referral required	
<b>Ambulance</b>	You pay \$225	
<b>Transportation</b>	Not covered	
<b>Medicare Part B Drugs</b>	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs Prior Authorization is required for Part B drugs. Referral required	

Outpatient Prescription Drugs			
Deductible	You pay \$0		
	Retail Rx 30-day supply	Retail Rx 90-day supply	Mail Order 90-day supply
Initial Coverage			
Tier 1: Preferred Generic	You pay \$3	You pay \$9	You pay \$0
Tier 2: Non-Preferred Generic	You pay \$12	You pay \$36	You pay \$0
Tier 3: Preferred Brand	You pay \$47	You pay \$141	You pay \$131
Tier 4: Non-Preferred Brand	You pay \$100	You pay \$300	You pay \$290
Tier 5: Specialty Tier	You pay 33%	You pay 33%	You pay 33%

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Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.	

**EXTRA/ENHANCED BENEFITS**

<ul style="list-style-type: none"> <li>Worldwide Emergency Coverage</li> </ul>	You pay \$120
<ul style="list-style-type: none"> <li>Fitness Benefit</li> </ul>	Silver and Fit: Basic membership to one plan approved fitness facility or 2 home workout kits per year. Referral required
<ul style="list-style-type: none"> <li>Remote access technologies</li> </ul>	Nursing hotline and Web/phone-based technologies: 12 visits per year, limited to Behavioral Health Specialist, Nutritionist and Urgent care. Referral required
<ul style="list-style-type: none"> <li>Enhanced alternative Rx</li> </ul>	Certain excluded drugs covered as a part of supplemental coverage (e.g. Drugs to treat erectile dysfunction)
<ul style="list-style-type: none"> <li>Over-the-Counter Benefits</li> </ul>	You receive a maximum of \$50 allowance every three months.