2019 Summary of Benefits

ILLINOIS

Clear Spring Health Essential Plus HMO

H5454, Plan 003 and H5454, Plan 004
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.

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 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. 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 Plus HMO
Monthly Plan Premium	You pay $47 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $3,400 annually Includes copays and other costs for medical services for the year.
Inpatient Hospital	You pay $175 per day for days 1 through 5 You pay nothing per day for days 6 through 90 Prior authorization is required. Referral required
Outpatient Hospital	You pay $100. Prior Authorization is required for outpatient services. Referral required
Doctor Visits	
• **Primary**	You pay nothing
• **Specialists**	You pay $15 per visit Prior authorization is required for specialist visits. Referral required

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Premiums and Benefits	Clear Spring Health Essential Plus HMO
Preventive Care (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.
Emergency Care	You pay $120 per visit.
Urgently Needed Services	You pay nothing

DIAGNOSTIC SERVICES/LABS/IMAGING

Diagnostic Services/Labs/Imaging • **Diagnostic tests and procedures**	You pay nothing. Referral required
• **Lab services**	You pay nothing. Referral required
• **MRI, CAT Scan**	You pay $45–$65. Referral required
• **X-Rays**	You pay nothing Prior authorization is required for some services. Referral required

HEARING SERVICES

Supplemental Benefits • **Routine hearing exam**	You pay nothing. Referral required
• **Fitting/Evaluation for hearing aid**	You pay nothing. Referral required
• **Hearing aid**	You pay nothing per hearing aid (all types). Maximum benefit of $1,000 annuall. Referral required
Medicare Covered Benefits • **Hearing Exams**	You pay $15 per visit Prior authorization is required for hearing exams. Referral required

DENTAL SERVICES

Preventive—Supplemental Benefits • **Oral exam & Cleaning** • **X-rays, Fluoride** • **Preventive Care Maximum**	You pay nothing, 1 visit every 6 months You pay nothing, 1 treatment per year $500 per year
Comprehensive— Supplemental Benefit • **Restorative services, endodontics, periodontics, extractions, prosthodontics**	You pay nothing. Maximum benefit $1,000 per year. Prior authorization is required. Referral required

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VISION SERVICES	
Supplemental Benefits	
• **Routine eye exam**	You pay nothing, 1 routine eye exam allowed annually. Referral required
• **Eyeglasses (frames and lenses)**	$200 Maximum benefit every year towards purchase Prior uthorization is required for eye exams and eyeglasses. Referral required
Medicare covered benefits.	
• **Eye Exams**	You pay $15 per visit. Referral required
Mental Health Services	
• **Outpatient group therapy/ individual therapy visit**	You pay $15. Prior authorization is required for mental health services. Referral required
• **Inpatient services**	You pay $175 per day for days 1 through 5. You pay nothing per day for days 6 through 90 Prior authorization is required for mental health inpatient services. Referral required
Skilled Nursing Facility	You pay nothing for days 1 through 20 You pay $172 per day for days 21 through 100 Prior Authorization is required for Skilled Nursing Facility. Referral required
Physical Therapy	You pay $15. Prior Authorization is required. Referral required
Ambulance	You pay $125
Transportation	Not covered

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Medicare Part B Drugs	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 nothing	You pay nothing	You pay nothing
Tier 2: Non-Preferred Generic	You pay $6	You pay $12	You pay $12
Tier 3: Preferred Brand	You pay $35	You pay $70	You pay $70
Tier 4: Non-Preferred Brand	You pay $185	You pay $255	You pay $225
Tier 5: Specialty Tier	You pay 33%	You pay 33%	You pay 33%
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

• Worldwide Emergency Coverage	You pay $120
• Fitness Benefit	Silver and Fit: Basic membership to one plan approved fitness facility or 2 home workout kits per year. Referral required
• Remote access technologies	Nursing hotline and Web/phone-based technologies: 12 visits per year, limited to Behavioral Health Specialist, Nutritionist and Urgent care. Referral required
• Enhanced alternative Rx	Certain excluded drugs covered as a part of supplemental coverage (e.g. Drugs to treat erectile dysfunction)