Summary of Benefits – Clear Spring Health Essential (PPO)

This is a summary of health and drug services covered by **Clear Spring Health Essential (PPO)** from January 1, 2023 - December 31, 2023.

Clear Spring Health has a contract with Medicare to offer HMO, PPO, and PDP Plans. Clear Spring Health has contracts with the Georgia and South Carolina Medicaid programs. Enrollment in these plans is dependent on annual contract renewal with the federal government.

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 visit www.clearspringhealthcare.com for the 2023 "***Evidence of Coverage***," or call 1-877-364-4566 to request a copy of the Evidence of Coverage to be mailed to you. The Evidence of Coverage will be available on our website by no later than October 15, 2022.

To join **Clear Spring Health Essential (PPO),** 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 Colorado: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld.

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.

Call us or go online for more information.

Not a member yet? Call 1-877-364-4566 (TTY:711)
From October 1st – March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
From April 1st – September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.
Already a member? Call 1-877-364-4566 (TTY:711)
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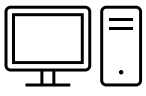

Website: Clearspringhealthcare.com

Premiums and Benefits	Clear Spring Health Essential (PPO)	
Monthly Plan Premium	$0	
	You must continue to pay your Medicare Part B premium.	
Deductible	$0 for medical services	
Maximum Out-of-Pocket	○ $5,500 for in-network Medicare-covered services ○ $8,950 combined for both in-network and out-of-network Medicare-covered services	
Benefit Category	**In Network**	**Out-of-Network**
Inpatient Hospital – Acute	○ $300 copay per day for days 1-5; $0 copay per day for days 6-90 ○ Prior authorization is required.	○ 45% coinsurance for days 1-5; 45% for days 6-90. ○ Prior authorization is required.
Inpatient Hospital – Psychiatric	○ $275 copay per day for days 1-6; $0 copay per day for days 7-90 ○ Prior authorization is required.	○ 45% coinsurance for days 1-5; 45% for days 6-90. ○ Prior authorization is required.
Outpatient Hospital	○ $45 to $340 copay ○ $45 copayment for some skin tag removals performed at a dermatologist's office. $340 copayment for all other services. authorization required for Medicare-covered Observation Services after 24 hours ○ Prior authorization is required.	○ 45% of the total cost ○ Prior authorization is required.
Ambulatory Surgical Center (ASC) Services	○ $45-$290 copay for Medicare-covered services ○ $45 copayment for some skin tag removals performed at a dermatologist's office. $290 copayment for all other services. ○ Prior authorization is required.	○ 45% coinsurance for Medicare-covered services ○ Prior authorization is required.
Doctor Visits ○ Primary Care ○ Specialists	○ $0 copay for Primary Care	○ 45% of the total cost for Primary Care
	○ $0 copay for Endocrinologist Specialist. $20 copay for all other Specialists.	○ 45% of the total cost for specialist services

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Deductible	$0 for medical services	
Maximum Out-of-Pocket	○ $5,500 for in-network Medicare-covered services ○ $8,950 combined for both in-network and out-of-network Medicare-covered services	
Benefit Category	**In Network**	**Out-of-Network**
Preventive Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	○ $0 copay for preventive care services ○ No prior authorization required.	○ 45% of the total cost ○ No prior authorization required.
Emergency Care	○ $90 copay	○ $90 copay

Benefit Category	In-Network	Out-of-Network
Urgently Needed Services	○ $30 copay per visit	○ $30 copay per visit
Diagnostic Services	Diagnostic tests & procedures ○ $0 copay for Medicare-covered Diagnostic Procedures and Tests ○ No prior authorization required.	Diagnostic tests & procedures ○ 45% of the total cost ○ No prior authorization required.
	Lab Services ○ $0 copay for lab services	Lab Services ○ 45% of the total cost
	Diagnostic Radiology ○ $20 to $175 copay ○ $20 copayment for some diagnostic ultrasound and diagnostic bone density imaging. $175 copayment for all other Diagnostic Radiological Services (e.g., CT, MRI)	Diagnostic Radiology ○ 45% of the total cost
	Outpatient X-rays ○ $20 copay for outpatient x-rays ○	Outpatient X-rays ○ 45% of the total cost for outpatient x-rays
Hearing Services	○ $0 copay for fitting and evaluation for hearing aid ○ unlimited number of visits ○ $0 copay for hearing aids ○ $500 maximum plan coverage amount per ear for in- and out-of-network hearing aid benefits every year ○ Hearing aids must be purchased through NationsHearing in order to access the benefit. ○ No prior authorization required.	○ 45% of the total cost for Medicare-covered hearing exams

<table>
<tr><td>Dental Services</td><td colspan="2"><u>Preventive Dental</u>

$0 copay for one oral exam every six months, one cleaning every six months, x-rays, and fluoride treatment once a year.

<u>Comprehensive Dental</u>

$0 copay for comprehensive dental services. See Chapter 4 of the Evidence of Coverage for more details.

Benefit Limit: $1,500 maximum plan coverage amount for in- and out-of-network comprehensive dental benefits every year. If you choose to see an out-of-network dentist, you might be billed more, even for services listed as $0 copay.</td></tr>
<tr><th></th><th><u>In-Network</u></th><th><u>Out-of-Network</u></th></tr>
<tr><td>Vision Services</td><td>o $0 copay for Medicare-covered eye exams
o $0 copay for eye wear
o $150 maximum plan coverage amount for in-network routine eye wear benefits combined every year</td><td>o 45% of the total cost for Medicare-covered eye exams
o 45% of the total cost for eye wear</td></tr>
<tr><td rowspan="2">Mental Health Services</td><td>Mental Health Specialty Services
o $40 copay per visit for individual sessions
o $40 copay per visit for group sessions
o No prior authorization required.</td><td>Mental Health Specialty Services
o 45% of the total cost for individual sessions
o 45% of the total cost for group sessions
o No prior authorization required.</td></tr>
<tr><td>Psychiatric Services
o $40 copay per visit for individual sessions
o $40 copay per visit for group sessions
o No prior authorization required.</td><td>Psychiatric Services
o 45% of the total cost for individual sessions
o 45% of the total cost for group sessions
o No prior authorization required.</td></tr>
<tr><td>Skilled Nursing Facility</td><td>o $0 copay per day for days 1-20; $178 copay per day for days 21-100
o Prior authorization is required.</td><td>o 45% coinsurance for days 1-20; 45% for days 21-100.
o Prior authorization is required.</td></tr>
<tr><td>Physical Therapy</td><td>o $40 copay
o Prior authorization is required.</td><td>o 45% of the total cost
o Prior authorization is required.</td></tr>
<tr><td>Ambulance</td><td>o $270 copay for ground transportation
o $270 copay for air transportation</td><td>o $275 copay for ground transportation
o $275 copay for air transportation</td></tr>
</table>

Transportation	○ $0 copay ○ up to 24 one-way trips every year to plan-approved locations	○ $0 copay ○ up to 24 one-way trips every year to plan-approved locations
Medicare Part B Drugs	○ 20% of the total cost for Medicare Part B Drugs (for a list of Medicare Part B Drugs, call our Member Services department at 1-877-364-4566) ○ 20% of the total cost for Chemotherapy ○ Prior authorization is required.	○ 45% of the total cost for Medicare Part B Drugs (for a list of Medicare Part B Drugs, call our Member Services department at 1-877-364-4566) ○ 45% of the total cost for Chemotherapy ○ Prior authorization is required.

Prescription Drugs				
Deductible	$0			
Initial Coverage	Preferred Retail Rx 30-day Supply	Non-Preferred Retail Rx 30-day Supply	Preferred Mail Order 90-day Supply	Long-Term Care 31-day Supply
Tier 1: Preferred Generic	$0 copay	$9 copay	$0 copay	$9 copay
Tier 2: Generic	$7 copay	$14 copay	$21 copay	$14 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay	$47 copay
Tier 4: Non-Preferred Drug	$95 copay	$100 copay	$285 copay	$100 copay
Tier 5: Specialty	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance

Coverage Gap or "Donut Hole"	Most Medicare drug plans have a Coverage Gap or "donut hole." This means that there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after the total yearly drug costs (including what **Clear Spring Health Essential (PPO)** has paid and what you have paid) reaches $4,660. Please note that not everyone will enter the Coverage Gap. For the 2023 plan year, while in the Coverage Gap, you will pay 25% of the total cost for drugs until you reach $7,400 total out-of-pocket.
Select Insulins	**Clear Spring Health Essential (PPO)** offers coverage for select insulins. Your out-of-pocket costs for these select insulins will be $35 for a 30-day supply at a standard retail pharmacy and $30 for a 30-day supply for a preferred, in-network pharmacy.
Catastrophic Coverage	After you reach $7,400 yearly out-of-pocket drug costs, you pay the greater of: o 5% of the cost -or- o $4.15 copay for generic (including brand drugs treated as generic) o $10.35 copay for all other drugs
Additional Benefits	
Over the Counter (OTC)	Plan covers up to $150 every three months. Unused portions do not carry over to the next period.
Special Supplemental Benefits for the Chronically Ill	For members with a qualifying chronic condition, an allowance of $55 per month will be available for healthy foods and/or produce.
Flex Benefits for Dental, Vision, and Hearing	In addition to the regular dental, vision, and hearing benefits, an additional $250 per quarter is available via a pre-loaded Mastercard from Nations Benefits, to be used at any qualifying dental, vision, or hearing merchant.
Meals after inpatient hospital stay	**Clear Spring Health Essential (PPO)** provides up to 20 meals, up to 28 days after each discharge; meals provided through Nations Benefits. $0 copay for meals