

Clear Spring Health Essential (HMO) offered by Clear Spring Health (VA), INC.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Clear Spring Health Essential (HMO). Next year, there will be changes to the plan's costs and benefits. *Please see page 3 for a Summary of Important Costs, including Premium.*

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.clearspringhealthcare.com. (You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital)
 - Review the changes to our drug coverage, including authorization requirements and costs
 - Think about how much you will spend on premiums, deductibles, and cost sharing
- Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Clear Spring Health Essential (HMO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Clear Spring Health Essential (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1 (877) 364-4566 for additional information. (TTY users should call 711.) Hours are from October 1 – March 31, 8:00 a.m. - 8:00 p.m., seven days a week and from April 1 – September 30, 8:00 a.m. - 8:00 p.m., Monday through Friday (you may leave a voicemail Saturday, Sunday, and Federal Holidays).
- This document is available in braille, large print, and audio.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Clear Spring Health Essential (HMO)

- 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.
- When this document says “we,” “us,” or “our,” it means Clear Spring Health (VA), INC. When it says “plan” or “our plan,” it means Clear Spring Health Essential (HMO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Clear Spring Health Essential (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium*	\$0	\$0
* Your premium may be higher than this amount. See Section 1.1 for details.		

Cost	2022 (this year)	2023 (next year)
<p>Maximum out-of-pocket amount \$3,250</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$3,250	\$3,250
<p>Doctor office visits</p>	<p>Primary care visits: \$0 copay per visit</p> <p>Specialist visits: \$25 copay per visit</p>	<p>Primary care visits: \$0 copay per visit</p> <p>Specialist visits: \$0 to \$30 copay per visit</p> <p>\$0 copay for Endocrinologist Specialist. \$30 copay for all other Specialists.</p>
<p>Inpatient hospital stays</p>	<p>\$250 copay per day for days 1-6; \$0 copay per day for days 7-90</p>	<p>\$250 copay per day for days 1-6; \$0 copay per day for days 7-90</p>
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$0</p> <p><i>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</i></p> <p>Drug Tier 1: \$9 copay</p> <p>Drug Tier 2: \$12 copay</p> <p>Drug Tier 3: \$47 copay</p> <p>Drug Tier 4: \$100 copay</p> <p>Drug Tier 5: 33% coinsurance</p>	<p>Deductible: \$0</p> <p><i>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</i></p> <p>Drug Tier 1: \$9 copay</p> <p>Drug Tier 2: \$12 copay</p> <p>Drug Tier 3: \$47 copay</p> <p>Drug Tier 4: \$100 copay</p> <p>Drug Tier 5: 33% coinsurance</p>

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay “out-of-pocket” for the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$3,250	\$3,250 Once you have paid \$3,250 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.clearspringhealthcare.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are no changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Chiropractic Services (Non-Medicare-covered)	<u>In-Network</u> You pay \$0 copay for each visit (unlimited number of visits).	<u>In-Network</u> Not covered

Cost	2022 (this year)	2023 (next year)
<p>Dental Services (Non-Medicare-covered Comprehensive)</p>	<p><u>In-Network</u> Extraction services Not covered Endodontic services Not covered Periodontics Not covered \$0 copay for each prosthodontics and other oral/maxillofacial surgery services visit (unlimited number of visits). \$1,500 maximum plan coverage amount for non-Medicare-covered comprehensive dental benefits every year</p>	<p><u>In-Network</u> \$0 copay for each extraction services visit (unlimited number of visits). \$0 copay for each endodontics services visit (unlimited number of visits). You pay \$0 copay for each periodontics services visit (unlimited number of visits). You pay \$0 copay for each prosthodontics and other oral/maxillofacial surgery services visit (unlimited number of visits). \$1,500 maximum plan coverage amount for non-Medicare-covered comprehensive dental benefits every year</p>
<p>Dental Services (Preventive)</p>	<p><u>In-Network</u> You pay \$0 copay for each fluoride treatment (1 fluoride treatment every year). You pay \$0 copay for X-rays (1 x-ray).</p>	<p><u>In-Network</u> You pay \$0 copay for each fluoride treatment (1 fluoride treatment every year). You pay \$0 copay for X-rays (2 x-rays).</p>
<p>Durable Medical Equipment (DME) and Related Supplies</p>	<p><u>In-Network</u> You pay 20% of the total cost for Medicare-covered DME. Prior authorization is required.</p>	<p><u>In-Network</u> You pay 20% of the total cost for Medicare-covered DME. Prior authorization required for items in excess of \$500.</p>

Cost	2022 (this year)	2023 (next year)
Emergency Services	<p><u>In- and Out-of-Network</u> You pay \$120 copay per visit for each visit for Medicare-covered emergency services.</p> <p>Copay will be waived if you are admitted to the hospital within one (1) day(s) for the same condition.</p>	<p><u>In- and Out-of-Network</u> You pay \$120 copay for each visit for Medicare-covered emergency services.</p> <p>Copay is waived if you are admitted to the hospital within 1 day</p>
Combined Flex Benefit for Dental/Vision/Hearing	<p>Not Covered</p>	<p>\$250 per quarter is available via a pre-loaded Mastercard from Nations Benefits, to be used at any qualifying dental, vision, or hearing merchant.</p>
Hearing Aids	<p><u>In-Network</u> You pay \$250 to \$1800 copay for hearing aids (2 hearing aids every three years).</p>	<p><u>In-Network</u> You pay \$0 copay for hearing aids (2 hearing aids every year).</p> <p>\$500 maximum plan coverage amount per ear for hearing aid benefits every year</p>
Over-the-Counter Items	<p><u>In-Network</u> You pay \$0 copay for OTC items.</p> <p>Plan covers up to \$100 every three months.</p>	<p><u>In-Network</u> You pay \$0 copay for OTC items.</p> <p>Plan covers up to \$150 every three months.</p>
Re-Admission Prevention	<p><u>In-Network</u> Not covered</p>	<p><u>In-Network</u> \$0 copay</p> <p>The plan provides up to 20 meals up to 28 days after each discharge.</p>

Cost	2022 (this year)	2023 (next year)
Special Supplemental Benefits for the Chronically III	<u>In-Network</u> Not covered	<u>In-Network</u> Up to \$55 per month toward healthy food and produce. Prior authorization is required.
Specialist Visits	<u>In-Network</u> You pay \$25 copay per visit for each Medicare-covered specialist visit.	<u>In-Network</u> You pay \$0 to \$30 copay per visit for each Medicare-covered specialist visit. \$0 copay for Endocrinologist Specialist. \$30 copay for all other Specialists.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Starting in 2023, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep

the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by *December 1st, 2022*, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

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.

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.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at \$35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800- MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Member Services number at 1-877-364-4566 for additional information. (TTY users should call 711.) We are available for phone calls from October 1 – March 31, 8:00 a.m. - 8:00 p.m., seven days a week and from April 1 – September 30, 8:00 a.m. - 8:00 p.m., Monday through Friday (you may leave a voicemail Saturday, Sunday, and Federal Holidays). Calls to these numbers are free.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
<p>Stage 1: Yearly Deductible Stage</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
<p>Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p>	<p>Your cost for a one-month supply at a network pharmacy:</p>
<p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.</p>	<p>Preferred Generic: <i>Standard cost sharing:</i> You pay \$9 copay per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$2 copay per prescription.</p>	<p>Preferred Generic: <i>Standard cost sharing:</i> You pay \$9 copay per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$2 copay per prescription.</p>
<p>For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	<p>Generic: <i>Standard cost sharing:</i> You pay \$12 copay.</p>	<p>Generic: <i>Standard cost sharing:</i> You pay \$12 copay.</p>

Stage	2022 (this year)	2023 (next year)
<p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p>	<p><i>Preferred cost sharing:</i> You pay \$5 copay.</p> <p>Preferred Brand: <i>Standard cost sharing:</i> You pay \$47 copay.</p> <p><i>Preferred cost sharing:</i> You pay \$42 copay.</p> <p>Non-Preferred Drug: <i>Standard cost sharing:</i> You pay \$100 copay.</p> <p><i>Preferred cost sharing:</i> You pay \$95 copay.</p>	<p><i>Preferred cost sharing:</i> You pay \$5 copay.</p> <p>Preferred Brand: <i>Standard cost sharing:</i> You pay \$47 copay.</p> <p><i>Preferred cost sharing:</i> You pay \$42 copay.</p> <p>Non-Preferred Drug: <i>Standard cost sharing:</i> You pay \$100 copay.</p> <p><i>Preferred cost sharing:</i> You pay \$95 copay.</p>
	<p>Specialty Tier: <i>Standard cost sharing:</i> You pay 33% coinsurance.</p> <p><i>Preferred cost sharing:</i> You pay 33% coinsurance.</p>	<p>Specialty Tier: <i>Standard cost sharing:</i> You pay 33% coinsurance.</p> <p><i>Preferred cost sharing:</i> You pay 33% coinsurance.</p>
	<p>Once your total drug costs have reached \$4,430, you will move to the next stage (the Coverage Gap Stage). Once you have paid \$7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage). Once you have paid \$7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Clear Spring Health Essential (HMO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Clear Spring Health Essential (HMO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2). As a reminder, Clear Spring Health Essential (HMO) offers other Medicare health plans *AND/OR* Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Clear Spring Health Essential (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Clear Spring Health Essential (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll or visit our website to disenroll online. Contact Member Services if you need more information on how to do so.
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

See the table below for the State Health Insurance Program (SHIP) name and contact information in Virginia.

State	SHIP Agency	Address	Phone Number/TTY	Web Address
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP)	1610 Forest Avenue, Suite 100 Richmond, VA 23229	1-800-552-3402 TTY: 711	https://www.vda.virginia.gov/vicap.htm

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).
- **Help from your state’s pharmaceutical assistance program.** Virginia has a program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

State	SPAP Agency	Address	Phone Number/TTY	Web Address
Virginia	Virginia Medication Assistance Program (MAP)	Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street Richmond, VA 23219	1-855-362-0658 TTY: 711	https://www.vdh.virginia.gov/disease-prevention/vamap/

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, see the table below for contact information for the ADAP in Virginia.

State	ADAP Agency	Address	Phone Number/TTY	Web Address
Virginia	Virginia Department of Health (VDH) AIDS Drug Assistance Program	Virginia Department of Health, HCS Unit, 1 st Floor James Madison Building, 109 Governor Street Richmond, VA 23219	1-855-362-0658 TTY: 711	https://www.vdh.virginia.gov/

SECTION 6 Questions?

Section 6.1 – Getting Help from Clear Spring Health Essential (HMO)

Questions? We're here to help. Please call Member Services at 1-877-364-4566. (TTY only, call 711.) We are available for phone calls Monday through Friday, from 8 a.m. to 8 p.m., seven days a week, and April 1 - September 30th, 8:00 am - 8:00 pm, Monday through Friday. Calls to these numbers are free.

Read your 2023 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for Clear Spring Health Essential (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.clearspringhealthcare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.clearspringhealthcare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (*Formulary/Drug List*).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or 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.