2024 SUMMARY OF BENEFITS

ILLINOIS
COLORADO

Clear Spring Health

H5454-005 Clear Spring Health Essential (HMO C-SNP)
COUNTIES: Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson, Winnebago

H5454-006 Clear Spring Health Essential (HMO C-SNP)
COUNTIES: Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will

H6379-002 Clear Spring Health Essential (HMO C-SNP)
COUNTIES: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Huerfano, Jackson, Jefferson, Larimer, Morgan, Park, Pueblo, Teller, Washington, Weld

Summary of Benefits

This is a summary of health and drug services covered by Clear Spring Health from January 1, 2024 – December 31, 2024

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 2024 "*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, 2023.

To join **Clear Spring Health Essential (HMO C-SNP),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

If you use providers that are not in our network, we may not pay for these services. This document is available in other formats such as braille, large print, or audio.

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 yet a member? 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)
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.

Website: clearspringhealthcare.com

Important Rules:

• In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

• 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, premiums and/or copayments/co-insurance may change on January 1, 2024

	H5454-005 Clear Spring Health Essential (HMO C-SNP)	H5454-006 Clear Spring Health Essential (HMO C-SNP)	H6379-002 Clear Spring Health Essential (HMO C-SNP)
	Benefits with a (+) may require prior authorization		
Monthly Plan Premium	$0 You must continue to pay your Part B premium	$0 You must continue to pay your Part B premium	$0 You must continue to pay your Part B premium
Deductible	$0 deductible for medical. See prescription drugs section for Part D deductible.	$0 deductible for medical. See prescription drugs section for Part D deductible.	$0 deductible for medical. See prescription drugs section for Part D deductible.
Maximum Out-of-Pocket (*does not include Part D prescription drugs*)	$6,700	$6,700	$6,700
Inpatient Hospital Coverage – Acute (+)	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90
Inpatient Hospital Coverage – Psychiatric (+)	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90
Outpatient Hospital Coverage (+)	$225 copay	$225 copay	$225 copay
Ambulatory Surgical Center (ASC) Services (+)	$175 copay	$175 copay	$175 copay

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Doctor Visits (Primary Care Providers and Specialists) (+)	$0 copay for primary care visits $0 to $25 copay for specialist visits $0 copay for Endocrinologist Specialist. $25 copay for all other Specialists.	$0 copay for primary care visits $0 to $25 copay for specialist visits $0 copay for Endocrinologist Specialist. $25 copay for all other Specialists.	$0 copay for primary care visits $0 to $25 copay for specialist visits $0 copay for Endocrinologist Specialist. $25 copay for all other Specialists.
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	$0 copay	$0 copay	$0 copay
Emergency Care	$80 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	$80 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	$80 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.
Urgently Needed Services	$50 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	$50 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	$50 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.

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Diagnostic Services/Labs/Imaging Diagnostic tests and procedures Lab Services Diagnostic Radiology Outpatient x-rays (+)	20% of the total cost for diagnostic procedures and tests $5 copay for lab services $25 copay for xrays	20% of the total cost for diagnostic procedures and tests $5 copay for lab services $25 copay for xrays	20% of the total cost for diagnostic procedures and tests $5 copay for lab services $25 copay for xrays
Hearing Services Routine Hearing Exam Hearing Aids	$30 copay for Medicare-covered hearing exams $0 copay for routine, non-Medicare covered hearing exams $500 maximum plan coverage amount every year (per ear) for hearing aids. 2 hearing aids every year Routine hearing services, including hearing aids, are available only through NationsBenefits.	$30 copay for Medicare-covered hearing exams $0 copay for routine, non-Medicare covered hearing exams $500 maximum plan coverage amount every year (per ear) for hearing aids. 2 hearing aids every year Routine hearing services, including hearing aids, are available only through NationsBenefits.	$30 copay for Medicare-covered hearing exams $0 copay for routine, non-Medicare covered hearing exams $500 maximum plan coverage amount every year (per ear) for hearing aids. 2 hearing aids every year Routine hearing services, including hearing aids, are available only through NationsBenefits.
Dental Services	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay

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	$0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services.	$0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services.	$0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services.
Vision Services	$30 copay for Medicare-covered eye exam 1 routine vision exam every year at $0 copay 1 pair of eyeglasses every year $100 maximum plan coverage amount for all non-Medicare-covered eyewear.	$30 copay for Medicare-covered eye exam 1 routine vision exam every year at $0 copay 1 pair of eyeglasses every year $100 maximum plan coverage amount for all non-Medicare-covered eyewear.	$30 copay for Medicare-covered eye exam 1 routine vision exam every year at $0 copay 1 pair of eyeglasses every year $100 maximum plan coverage amount for all non-Medicare-covered eyewear.
Mental Health Services	$30 copay for individual sessions $30 copay for group sessions	$30 copay for individual sessions $30 copay for group sessions	$30 copay for individual sessions $30 copay for group sessions
Skilled Nursing Facility (+)	$0 copay per day for days 1-20; $167 copay per day for days 21-100	$0 copay per day for days 1-20; $167 copay per day for days 21-100	$0 copay per day for days 1-20; $167 copay per day for days 21-100

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Physical Therapy (+)	$40 copay	$40 copay	$40 copay
Ambulance (+)	$225 copay for ground ambulance transportation $225 copay for air transportation Prior authorization is required for non-emergency Medicare ground transportation services.	$225 copay for ground ambulance transportation $225 copay for air transportation Prior authorization is required for non-emergency Medicare ground transportation services.	$225 copay for ground ambulance transportation $225 copay for air transportation Prior authorization is required for non-emergency Medicare ground transportation services.
Transportation (+)	up to 24 round trips every year to plan-approved health-related locations	up to 24 round trips every year to plan-approved health-related locations	up to 24 round trips every year to plan-approved health-related locations
Medicare Part B Drugs	0% to 20% of the total cost for Insulin 0% to 20% of the total cost for Chemotherapy 0% to 20% of the total cost for Other Part B drugs	0% to 20% of the total cost for Insulin 0% to 20% of the total cost for Chemotherapy 0% to 20% of the total cost for Other Part B drugs	0% to 20% of the total cost for Insulin 0% to 20% of the total cost for Chemotherapy 0% to 20% of the total cost for Other Part B drugs

	PRESCRIPTION DRUGS H5454-005 Clear Spring Health Essential (HMO C-SNP)				
Stage 1: Deductible Stage	**$250** Deductible applies to: **Tier 3, Tier 4, and Tier 5**				
Stage 2: Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and the plan.				
Coverage Gap	The plans do not provide additional coverage gap. You stay in the Initial Coverage Stage until your out-of-pocket costs reach $8,000. Not everyone will enter the coverage gap. You will then move on to the Catastrophic Coverage Stage.				
Catastrophic Coverage Stage	During the Catastrophic Coverage Stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.				
Pharmacy Type	Preferred Retail 30-day supply	Non-Preferred Retail 30-day supply	Preferred 90-day supply	Non-Preferred 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	$20 copay	$0 copay	$50 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	29% of the total cost	29% 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.	29% of the total cost

	PRESCRIPTION DRUGS H5454-006 Clear Spring Health Essential (HMO C-SNP)				
Stage 1: Deductible Stage	**$250** Deductible applies to: **Tier 3, Tier 4, and Tier 5**				
Stage 2: Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and the plan.				
Coverage Gap	The plans do not provide additional coverage gap. You stay in the Initial Coverage Stage until your out-of-pocket costs reach $8,000. Not everyone will enter the coverage gap. You will then move on to the Catastrophic Coverage Stage.				
Catastrophic Coverage Stage	During the Catastrophic Coverage Stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.				
Pharmacy Type	Preferred Retail 30-day supply	Non-Preferred Retail 30-day supply	Preferred 90-day supply	Non-Preferred 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	$20 copay	$0 copay	$50 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	29% of the total cost	29% 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.	29% of the total cost

	PRESCRIPTION DRUGS H6379-002 Clear Spring Health Essential (HMO C-SNP)				
Stage 1: Deductible Stage	**$250** Deductible applies to: **Tier 3, Tier 4, and Tier 5**				
Stage 2: Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and the plan.				
Coverage Gap	The plans do not provide additional coverage gap. You stay in the Initial Coverage Stage until your out-of-pocket costs reach $8,000. Not everyone will enter the coverage gap. You will then move on to the Catastrophic Coverage Stage.				
Catastrophic Coverage Stage	During the Catastrophic Coverage Stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.				
Pharmacy Type	Preferred Retail 30-day supply	Non-Preferred Retail 30-day supply	Preferred 90-day supply	Non-Preferred 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	$20 copay	$0 copay	$50 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	29% of the total cost	29% 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.	29% of the total cost

	H5454-005 Clear Spring Health Essential (HMO C-SNP)	H5454-006 Clear Spring Health Essential (HMO C-SNP)	H6379-002 Clear Spring Health Essential (HMO C-SNP)
	ADDITIONAL BENEFITS		
Over the Counter	$75 maximum plan coverage amount per month for OTC items. OTC items are available online through NationsBenefits or at participating network retailers. Unused portion does not carry over to the next period.	$75 maximum plan coverage amount per month for OTC items. OTC items are available online through NationsBenefits or at participating network retailers. Unused portion does not carry over to the next period.	$75 maximum plan coverage amount per month for OTC items. OTC items are available online through NationsBenefits or at participating network retailers. Unused portion does not carry over to the next period.
Utilities (General Supports for Living)	$75 per month for gas, electric, water, or internet. Monthly contact required, along with copy of receipt. Amount does not rollover.		
Special Supplemental Benefits for the Chronically Ill	**$112** per month for groceries. A completed health risk assessment, indicating a qualifying chronic condition is required. Groceries are available through NationsBenefits or from participating network retailers. Unused portion does not carry over to the next period.	**$112** per month for groceries. A completed health risk assessment, indicating a qualifying chronic condition is required. Groceries are available through NationsBenefits or from participating network retailers. Unused portion does not carry over to the next period.	**$110** per month for groceries. A completed health risk assessment, indicating a qualifying chronic condition is required. Groceries are available through NationsBenefits or from participating network retailers. Unused portion does not carry over to the next period.
Meals after Inpatient Hospital stay	The plan will provide up to 20 meals for 28 days after each discharge; two discharges per year.		

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, or $30 for a month supply of each insulin product covered by our plan at a preferred 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.