2024 SUMMARY OF BENEFITS

GEORGIA AND SOUTH CAROLINA

Clear Spring Health

Clear Spring Health Deluxe Plan (HMO D-SNP)
Georgia
H6672-001
Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, DeKalb, Dodge, Dooly, Fayette, Forsyth, Franklin, Greene, Hancock, Hart, Heard, Henry, Houston, Jasper, Jones, Lamar, Lumpkin, Macon, Madison, McIntosh, Meriwether, Monroe, Morgan, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Stephens, Talbot, Taliaferro, Taylor, Twiggs, Walton, White, Wilcox, Wilkinson

Clear Spring Health Deluxe Plan (HMO D-SNP)
South Carolina
H9403-001
Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg, Union

Summary of Benefits

This is a summary of health and drug services covered by Clear Spring Health Essential (HMO) 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 Deluxe Plan (HMO D-SNP),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

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 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.

MAPD D-SNP Health Plan Covered Dual Eligible Categories		
H6672	001	QMB Only, QMB Plus, SLMB Plus, and FBDE
H9403	001	QMB Plus, SLMB Plus, and FBDE

You can enroll in this plan if you are in one of these Medicaid categories:

Qualified Medicare Beneficiary (QMB): If you are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays the Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

Qualified Medicare Beneficiary Plus (QMB Plus): If you are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays the Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits.

Specified Low-Income Medicare Beneficiary (SLMB Plus): An individual who meets the financial criteria for full Medicaid coverage. Such individuals are entitled to payment of Medicare Part B premiums, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient. These individuals often qualify for Medicaid by meeting the Medically Needy standards, or though spending down excess income to the Medically Needy level.

Full Benefits Dual Eligible (FBDE): Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672-001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
	Benefits with a (+) may require prior authorization	
Monthly Plan Premium	Part D Premium: $36.10 You must continue to pay your Part B premium.	Part D Premium: $40.90 You must continue to pay your Part B premium.
Deductibles (Does not include prescription drugs)	• Medicare Part B Deductible: $226. After your deductible is met, you pay 20% of the Medicare-approved amount for these services. • Inpatient Hospital Acute and Psychiatric: The 2024 Part A deductible is $1,600 for each inpatient hospital benefit period	• Medicare Part B Deductible: $226. After your deductible is met, you pay 20% of the Medicare-approved amount for these services. • Inpatient Hospital Acute and Psychiatric: The 2024 Part A deductible is $1,600 for each inpatient hospital benefit period
Maximum Out-of-Pocket	$8,850	$8,850
Inpatient Hospital Coverage – Acute (+)	$1,600 deductible for each benefit period. Days 1-60: $0 copay for each benefit period. Days 61-90: $400 copay per day of each benefit period. Days 91 and beyond: $800 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: All costs.	$1,600 deductible for each benefit period. Days 1-60: $0 copay for each benefit period. Days 61-90: $400 copay per day of each benefit period. Days 91 and beyond: $800 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: All costs.

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672-001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
Inpatient Hospital Coverage – Psychiatric (+)	$1,600 deductible for each benefit period. Days 1-60: 0% of the total cost for each benefit period. Days 61-90: $400 copay per day of each benefit period. Days 91 and beyond: $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: All costs.	$1,600 deductible for each benefit period. Days 1-60: 0% of the total cost for each benefit period. Days 61-90: $400 copay per day of each benefit period. Days 91 and beyond: $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: All costs.
Outpatient Hospital Coverage (+)	20% of the total cost	20% of the total cost
Ambulatory Surgical Center (ASC) Services (+)	20% of the total cost	20% of the total cost
Doctor Visits (Primary Care Providers and Specialists) (+)	20% of the total cost for primary care visits 20% of the total cost for specialist visits	20% of the total cost for primary care visits 20% of the total cost for specialist visits
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	$0 copay	$0 copay
Emergency Care	20% of the total cost, up to a $100 maximum ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	20% of the total cost, up to a $100 maximum ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672-001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
Urgently Needed Services	20% of the total cost, up to a $55 maximum Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	20% of the total cost, up to a $55 maximum Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.
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 20% of the total cost for lab services 20% of the total cost for x-rays	20% of the total cost for diagnostic procedures and tests 20% of the total cost for lab services 20% of the total cost for x-rays
Hearing Services Routine Hearing Exam Hearing Aids	20% of the total cost 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.	20% of the total cost 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.

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672-001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
Dental Services	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay $0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $4,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services.	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay $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	20% of the total cost 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.	20% of the total cost 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	20% of the total cost for individual sessions 20% of the total cost for group sessions	20% of the total cost for individual sessions 20% of the total cost for group sessions

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672-001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
Skilled Nursing Facility (+)	Days 1-20: $0 copay for each benefit period. Days 21-100: $200 copay per day of each benefit period. Days 101 and beyond: All costs.	Days 1-20: $0 copay for each benefit period. Days 21-100: $200 copay per day of each benefit period. Days 101 and beyond: All costs.
Physical Therapy (+)	20% of the total cost	20% of the total cost
Ambulance (+)	20% of the total cost for ground ambulance transportation 20% of the total cost for air transportation	20% of the total cost for ground ambulance transportation 20% of the total cost for air transportation
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.
Medicare Part B Drugs (+)	20% of the total cost for Insulin 20% of the total cost for Chemotherapy 20% of the total cost for Other Part B drugs	20% of the total cost for Insulin 20% of the total cost for Chemotherapy 20% of the total cost for Other Part B drugs

	PRESCRIPTION DRUGS H6672-001 Clear Spring Health Deluxe Plan (HMO D-SNP)				
Stage 1: Deductible Stage	**$545**				
Pre-Initial Coverage Limit Cost Share	**25%**				
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 plan does 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	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 2: Generic	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 3: Preferred Brand	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 4: Non-Preferred Drug	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 5: Specialty	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost

	PRESCRIPTION DRUGS H9403-001 Clear Spring Health Deluxe Plan (HMO D-SNP)				
Stage 1: Deductible Stage	**$545**				
Pre-Initial Coverage Limit	**25%**				
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	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 2: Generic	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 3: Preferred Brand	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 4: Non-Preferred Drug	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost
Tier 5: Specialty	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost	$0.00 to $11.20 of the total cost

	Clear Spring Health Deluxe Plan (HMO D-SNP) H6672_001	Clear Spring Health Deluxe Plan (HMO D-SNP) H9403-001
	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.
Utilities (General Supports for Living)	$75 per month for gas, electric, water, or internet. Monthly telephonic contact required, along with a copy of the receipt. Amount does not rollover.	$75 per month for gas, electric, water, or internet. Monthly telephonic contact required, along with a copy of the receipt. Amount does not rollover.
Special Supplemental Benefits for the Chronically Ill	**$105** 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.

Clear Spring Health

Georgia Medicaid
Summary of Benefits

Benefit	Co-Pay
Doctor and nurse office visits (when you visit a doctor or nurse for checkups, lab tests, exams, or treatment)	$0
Nursing Facility (nursing homes)	$0
Emergency ambulance services	$0
Certain emergency dental care for adults	$0
Non-emergency transportation (to get to and from medical appointments)	$0
Hospice care services provided by a Medicaid hospice provider	$0
Diagnostic, screening, and preventive services	$0
Laboratory services	$0
Mental health services	$0
Therapy services (physical, occupational, and speech)	$0
Rural Health Clinic and Federally Qualified Health Center services	$0
Dialysis and services for end-stage renal (kidney) disease	$0
Vision services	$0.50 to $3.00
Durable medical equipment (Medical equipment and supplies prescribed by a doctor for use in your home (such as wheelchairs, crutches, or walkers)	$3.00
Home health services ordered by a doctor and received in your home (such as part-time nursing, physical therapy, or home health aides)	$3.00 (co-pay does not apply to hospice care members)
Outpatient hospital services you receive in a hospital even though you do not stay in the hospital overnight	$3.00 (does not apply to women diagnosed with breast or cervical cancer who are receiving Medicaid under the Breast and Cervical Cancer (BCC) program $3.00 copay does not apply to hospice care members
Inpatient hospital services (room and board, drugs, lab tests, and other services when you have to stay in the hospital)	$12.50 for non-emergency inpatient hospital admissions
Prescription drugs	Preferred Generic: $0.50 Preferred Brand: $0.50 Non-Preferred Brand or Non-Preferred Generic: • Under $10=$0.50 copay • $10.01-$25.00 = $1.00 copay • $25.01-$50.00 = $2.00 copay • $50.01 or more = $3.00 copay

Clear Spring Health

South Carolina Medicaid
Summary of Benefits

Benefit	Service Benefit
Doctor and nurse office visits (when you visit a doctor or nurse for checkups, lab tests, exams, or treatment)	Covered
Nursing Facility (nursing homes)	Covered
Emergency ambulance services	Covered
Certain emergency dental care for adults	Covered
Non-emergency transportation (to get to and from medical appointments)	Covered
Hospice care services provided by a Medicaid hospice provider	Covered
Diagnostic, screening, and preventive services	Covered
Laboratory services	Covered
Mental health services	Covered
Therapy services (physical, occupational, and speech)	Covered
Vision services	Covered
Home health services ordered by a doctor and received in your home (such as part-time nursing, physical therapy, or home health aides)	Covered
Inpatient hospital services (room and board, drugs, lab tests, and other services when you have to stay in the hospital)	Covered
Prescription drugs	Covered

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.