Clear Spring Health

Summary of Benefits – *Clear Spring Health Community Flex Plan (HMO-POS)*

January 1, 2022 - December 31, 2022

Clear Spring Health cares about your well-being. Our health plans cover everything Original Medicare covers plus provide you with additional benefits to help improve your health care experience. Our goal is to promote healthy outcomes by providing robust primary and preventative care, access to personalized health and wellness services and a member first approach to health care delivery. This is important, especially as our country and the entire world continues to deal with COVID-19, a major public health crisis. We want to be there for you, through it all. So, we've enhanced some of our 2021 plan benefits, including offering our members an opportunity to receive a WIFI enabled tablet that will provide access to telehealth visits, educational health content and basic benefit information.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as *Clear Spring Health Community Flex Plan (HMO-POS)*.
- In an HMO plan, you pick one primary care physician. All your health care services go through that doctor. That means that you may need a referral before you can see any other health care professional, except in an emergency and urgent care. Visits to health care professionals outside of your network typically aren't covered by your insurance.

Tips for comparing your Medicare choices

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the 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.

Sections in this booklet

- Things to Know About the Health Care Plan
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

You must continue to pay your Medicare Part B premium.

Things to Know About the Health Care Plan

Hours of operation	• 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.
Phone numbers and website	• If you are a member of this plan, call toll-free 1-877-364-4566 • TTY/TDD users can call 711 • If you are not a member of this plan, call toll-free 1-877-364-4566 • Our website: www.clearspringhealthcare.com
Who can join?	To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the service area. The service area includes the following counties in Illinois: Boone, Cook, DuPage, Kane, McHenry, Ogle, Will, Winnebago
Which doctors, hospitals, and pharmacies can I use?	Clear Spring Health Community Flex Plan (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider directory and pharmacy directory on our website (www.clearspringhealthcare.com). Or call us and we will send you a copy of the provider and pharmacy directories.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers - and more. • For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less. • Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. • You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.clearspringhealthcare.com) • Or call us and we will send you a copy of the formulary
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Important—Please Note
Through this document you will see the symbols below.

- ♦ Services with this symbol may require prior authorization from the plan before you receive services.

If you do not get prior authorization when required, you may have to pay the full cost of the services. Please contact your PCP or refer to the Evidence of Coverage (EOC) for more information about services that require a referral and/or prior authorization from the plan.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?	$19 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible for medical services?	$0
Is there any limit on how much I will pay for my covered services? **What is my maximum out-of-pocket responsibility?**	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $2,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	The plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Benefit	Clear Spring Health Community Flex Plan (HMO-POS)
Inpatient Hospital Care ♦	The plan covers 90 days for an inpatient hospital stay. The plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • You pay a $220 copay per day for days 1-7; $0 copay per day for days 8-90 Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

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Doctor's Office Visits ♦	• You pay a $0 copay for an in-network Primary care physician visit • You pay a $0 copay for Primary Care Telehealth visits. • You pay a $0 copay per visit for all other Specialist visits.
Preventative Care	You are covered for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply.
Emergency Care	• You pay a $90 copay per visit for Emergency care. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Not covered outside the U.S.
Urgently Needed Services	• You pay a $35 copay per visit for Urgent care services.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may vary based on place of services) ♦	• Diagnostic radiology services (such as MRIs, CT scans): $0 to $100 copay • Diagnostic tests and procedures: $0 copay for Medicare-covered Diagnostic Procedures and Tests • Outpatient x-rays: $0 to $100 copay • Lab services: $0 copay • Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% of the total cost of the Medicare-approved amount.
Hearing Services ♦	• A Medicare-covered hearing exam to diagnose and treat hearing and balance issues: You pay a $0 copay. • A routine hearing exam (one (1) per year): $0 copay. • Hearing aid fitting/evaluations (one (1) for every 3 years): $0 copay. • Hearing aid copay: $0 copay. Notes: You will be able to purchase up to 2 hearing aids every 3 years with a maximum benefit allowance of $1000 for both ears combined. Hearing aids must be purchased through NationsHearing to have access to the benefit. You are responsible for any amount after the benefit allowance has been applied. There is no out-of-network option for supplemental hearing services.
Dental Services	Preventive dental services:

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	• Oral exam, cleaning, fluoride treatment (for up to one (1) every 6 months): $0 copay. • Dental x-rays, bitewing x-rays (for up to one (1) every year): $0 copay. You pay $0 copay for Medicare-covered comprehensive dental services: • Restorative Services: $0 copay • Diagnostic Services: $0 copay Our plan pays up to $4,000 maximum plan coverage amount for comprehensive dental benefits every year. Check PBP Report for IN-OON information. for most dental services. There is no out-of-network option for supplemental dental services.
Vision Services ♦	You pay a $0 copay for an exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). The plan covers one (1) pair of eyeglasses with standard frames (or one set of contact lenses) at no cost after a cataract surgery that implants an intraocular lens. • A routine eye exam (one (1) per year): $0 copay. • Eyeglasses (frames and lenses) or contact lenses (one (1) per year): $0 copay. The plan pays a $300 maximum plan coverage amount for in-network routine eye wear benefits combined every year, for eyeglasses (frames and lenses) or contact lenses. There is no out-of-network option for supplemental vision services.
Inpatient Mental Health Care ♦	The plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. • You pay a $220 copay per day for days 1-7; $0 copay per day for days 8-90 The plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. You pay all costs for each day after you use all the lifetime reserve days.
Outpatient Mental Health Care ♦	• Outpatient individual therapy visit: You pay a $0 copay per visit. • Outpatient group therapy visit: You pay a $0 copay per visit. • Outpatient partial hospitalization visit: You pay a $25 copayment.
Skilled Nursing Facility (SNF) ♦	The plan covers up to 100 days in a SNF. A three (3) day inpatient hospital stay is required prior to a SNF admission.

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	• You pay a $0 copay per day for days 1-20; $150 copay per day for days 21-100 You will not be charged additional cost sharing for professional services.
Ambulatory Surgical Center Services	• You pay a $175 copay.
Outpatient Rehabilitation ♦	• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay a $0 copay per visit. • Occupational therapy visits: You pay a $20 copay per visit. • Physical therapy and speech and language therapy visits: You pay a $20 copay for Medicare-covered benefits.
Ambulance ♦	• For each covered one-way trip on ground: You pay a $100 copay. • Covered air transportation: You pay 20% of the total cost.
Transportation (non-emergency)	You pay a $0 copay for up to 8 one-way trips every year to plan-approved locations.
Foot Care (podiatry services) ♦	You pay $0 copay per visit for Medicare covered Podiatry care and routine Podiatry services.
Durable Medical Equipment (wheelchairs, oxygen, etc.) ♦	Durable Medical Equipment (DME): You pay 20% of the total cost. If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.

Benefit	Clear Spring Health Community Flex Plan (HMO-POS)
Wellness Programs	
Health Club Membership SilverSneakers® Fitness	$0 copay for physical fitness to belong to a participating health club while you are a member of our plan. You can find a list of participating clubs on our website at www.clearspringhealthcare.com or call Member Services. You can call toll free 1 (877) 364-4566. TTY users should call 711. We can be reached 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.
Over-the-Counter Items	Our plan covers up to $25 every month for the purchase of covered over-the-counter items. Please visit our website at www.clearspringhealthcare.com to see our list of covered over-the-counter items.
Part B Drugs ♦	• For Part B drugs such as chemotherapy drugs: 20% of the total cost. • Other Part B drugs: 20% of the total cost.
Outpatient Substance Abuse ♦	Outpatient individual therapy visit: You pay a $40 copay. Outpatient group therapy visit: You pay a $40 copay.
Outpatient Hospital Care ♦	• Outpatient hospital: You pay $225 copay.
Diabetes Supplies and Services ♦	Diabetes monitoring supplies: 0% of the total cost. Therapeutic shoes or inserts: 20% of the total cost. Plan covers specified manufactures for diabetes monitoring supplies.
Prescription Drug Benefits	
Deductible	$0
Initial Coverage	You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. Medications administered as part of home infusion therapy require a 20% coinsurance. You may get drugs from an out-of-net- work retail pharmacy at the same cost as an in-network retail pharmacy.

Table 1

Retail Cost-Sharing (In-Network)	Preferred Retail One-Month Supply	Standard Retail One-Month Supply	Preferred Retail Three-Month Supply	Standard Retail Three-Month Supply
Tier 1 Preferred Generic	$0 copay	$5 copay	$0 copay	$5 copay
Tier 2 Generic	$12 copay	$17 copay	$5 copay	$10 copay
Tier 3 Preferred Brand	$42 copay	$47 copay	$105 copay	$117.50 copay
Tier 4 Non-Preferred Brand	$95 copay	$100 copay	$237.50 copay	$250 copay
Tier 5 Specialty	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance

Table 2

Mail Order Cost-Sharing	Preferred Mail Order One-Month Supply	Standard Mail Order One-Month Supply	Preferred Mail Order Three-Month Supply	Standard Mail Order Three-Month Supply
Tier 1 Preferred Generic	$0 copay	$5 copay	$0 copay	$5 copay
Tier 2 Generic	$12 copay	$17 copay	$5 copay	$10 copay
Tier 3 Preferred Brand	$42 copay	$47 copay	$105 copay	$117.50 copay
Tier 4 Non-Preferred Brand	$95 copay	$100 copay	$237.50 copay	$250 copay
Tier 5 Specialty	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance

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Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% of the cost, or • $3.95 copay for generic (including brand drugs treated as generic) and $9.85 for all other drugs.
Other Care and Services	
Remote Access Technology (Web/Phone-Based Technologies)	We will be offering a WIFI enabled tablet pre-loaded with software applications primarily focused on allowing our members to conduct telehealth visits, access educational content and basic benefit information, and to facilitate engagement with the Plan. A nursing professional is available 24 hours a day, 7 days a week.
Chiropractic Care ♦	Manipulation of the spine to correct a subluxation (when one (1) or more of the bones of your spine move out of position): You pay $0 copay per visit.
Home Health Care ♦	You pay a $0 copay.
Opioid Treatment Services ♦	You pay $0 copay for Medicare-covered Opioid Treatment Services.
Hospice	You must get care from a Medicare certified hospice. You must consult with your plan before you select hospice.
Prosthetic Devices (braces, artificial limbs, etc.) ♦	Prosthetic devices: You pay 20% of the total cost. Related medical supplies: You pay 20% of the total cost.
Renal Dialysis ♦	You pay 20% of the total cost.

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. CSH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Clear Spring Health Community Flex Plan (HMO-POS):

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, please **call toll free 1 (877) 364-4566. TTY users should call 711. We can be reached 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.**

If you believe that Clear Spring Health Community Flex Plan (HMO-POS) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator:

Attn: Civil Rights Coordinator
Clear Spring Health
250 S. Northwest Highway, Suite 302
Park Ridge, IL 60068

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Member Services department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,1-800-368-1019,800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html