



## 2023 Summary of Benefits – Clear Spring Health Community Advantage Plan (HMO)

This is a summary of health and drug services covered by **Clear Spring Health Community Advantage Plan (HMO)** 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](http://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 Community Advantage Plan (HMO)**, 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 Illinois: Boone, Cook, DuPage, Kane, McHenry, Ogle, Will, Winnebago.

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](http://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](http://Clearspringhealthcare.com)**

| <b>Premiums and Benefits</b>  |   |
|---|---|
| Monthly Plan Premium  | \$0   |
|   | You must continue to pay your Medicare Part B premium.  |
| Deductible  | \$0 for medical services  |
| Maximum Out-of-Pocket   | \$2,950   |
| Inpatient Hospital  | \$220 copay per day for days 1-7; \$0 copay per day for days 8-90<br>Prior authorization is required.   |
| Outpatient Hospital   | \$225 copay<br>Prior authorization is required.   |
| Doctor Visits <ul style="list-style-type: none"> <li>○ Primary Care</li> <li>○ Specialists</li> </ul>   | \$0 copay for Primary Care  |
| Preventive Care<br><br>(e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)  | \$0 copay for preventive care services<br>No prior authorization required   |
| Emergency Care  | \$90 copay<br>Copay is waived if you are admitted to the hospital within 24 hours   |
| Urgently Needed Services  | \$35 copay per visit<br>Copay will be waived if you are admitted to the hospital within 24 hour(s) for the same condition.  |
| Diagnostic Services <ul style="list-style-type: none"> <li>○ Diagnostic tests &amp; procedures</li> <li>○ Lab Services</li> <li>○ Diagnostic Radiology (e.g., MRI &amp; CT scans)</li> <li>○ Outpatient x-rays</li> </ul> | <u>Diagnostic tests &amp; procedures</u><br><br>\$0 copay for Medicare-covered Diagnostic Procedures and Tests<br>Prior authorization is required.  |
|   | <u>Lab Services</u><br><br>\$0 copay for lab services   |
|   | <u>Diagnostic Radiology</u><br><br>\$0 to \$100 copay<br>The minimum copay applies in the PCP setting and the maximum applies in the facility setting.  |
|   | <u>Outpatient X-rays</u><br>\$0 to \$100 copay for outpatient x-rays<br>\$0 copay for x-ray services if performed at a PCP office \$100 copay for x-ray services if performed at a specialist or facility |

|  |  |   |
|--|--|---|
| <p>Hearing Services</p> <ul style="list-style-type: none"> <li>○ Routine Hearing exam</li> <li>○ Hearing Aids</li> </ul> | <p>1 routine hearing exam every year<br/>\$0 copay for routine hearing exam<br/>No prior authorization required.</p>   |   |
|  | <p>\$0 copay for fitting and evaluation for hearing aid<br/>1 fitting and evaluation for hearing aids every three years<br/>\$0 copay for hearing aids<br/>\$500 maximum plan coverage amount per ear for hearing aid benefits every year<br/>Hearing aids must be purchased through NationsHearing in order to access the benefit.<br/>No prior authorization required.</p> |   |
| <p>Dental Services</p>   | <p><u>Preventive Dental</u></p> <p>\$0 copay for one oral exam every six months, one cleaning every six months, x-rays, and fluoride treatment once a year</p>   | <p><u>Comprehensive Dental</u></p> <p>\$0 copay for comprehensive dental services. See Chapter 4 of the Evidence of Coverage for more details</p> |
|  | <p>Benefit Limit: \$4,000 maximum plan coverage amount for non-Medicare-covered 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.</p>   |   |
| <p>Vision Services</p>   | <p>\$30 copay for Medicare-covered eye exams<br/>\$0 copay for eye wear<br/>\$300 maximum plan coverage amount for in-network routine eye wear benefits combined every year</p>  |   |
| <p>Mental Health Services</p>  | <p><u>Mental Health Specialty Services</u></p> <p>\$0 copay per visit for individual sessions<br/>\$0 copay per visit for group sessions<br/>No prior authorization required.</p>  |   |
|  | <p><u>Psychiatric Services</u></p> <p>\$30 copay per visit for individual sessions<br/>\$30 copay per visit for group sessions<br/>No prior authorization required.</p>  |   |
| <p>Skilled Nursing Facility</p>  | <p>\$0 copay per day for days 1-20; \$178 copay per day for days 21-100<br/>Prior authorization is required.</p>   |   |
| <p>Physical Therapy</p>  | <p>\$20 copay<br/>Prior authorization is required.</p>   |   |
| <p>Ambulance</p>   | <p>\$200 copay for ground transportation<br/>20% of the total cost for air transportation</p>  |   |
| <p>Transportation</p>  | <p>\$0 copay<br/>up to 12 one-way trips every year to plan-approved locations</p>  |   |
| <p>Medicare Part B Drugs</p>   | <p>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)<br/>20% of the total cost for Chemotherapy<br/>Prior authorization is required.</p>  |   |

**Prescription Drugs**

|                            |                                   |                                       |                                    |                              |
|----------------------------|-----------------------------------|---------------------------------------|------------------------------------|------------------------------|
| Deductible                 | \$0                               |                                       |                                    |                              |
| Initial Coverage Limit     | 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                         | \$5 copay                             | \$0 copay                          | \$0 copay                    |
| Tier 2: Generic            | \$12 copay                        | \$17 copay                            | \$5 copay                          | \$12 copay                   |
| Tier 3: Preferred Brand    | \$42 copay                        | \$47 copay                            | \$105 copay                        | \$47 copay                   |
| Tier 4: Non-Preferred Drug | \$95 copay                        | \$100 copay                           | \$237.50 copay                     | \$100 copay                  |
| Tier 5: Specialty          | 33% coinsurance                   | 33% coinsurance                       | 33% coinsurance                    | 33% coinsurance              |

|                              |  |
|------------------------------|--|
| Coverage Gap or “Donut Hole” | <p>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 <b>Clear Spring Health Community Advantage Plan (HMO)</b> has paid and what you have paid) reaches \$4,660. Please note that not everyone will enter the Coverage Gap.</p> <p>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.</p> |
| Select Insulins              | <p><b>Clear Spring Health Community Advantage Plan (HMO)</b> 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.</p>   |
| Catastrophic Coverage        | <p>After you reach \$7,400 yearly out-of-pocket drug costs, you pay the greater of:</p> <ul style="list-style-type: none"> <li>○ 5% of the cost -or-</li> <li>○ \$4.15 copay for generic (including brand drugs treated as generic)</li> <li>○ \$10.35 copay for all other drugs</li> </ul>  |

| <b>Additional Benefits</b>                            |  |
|---|--|
| 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                   | <b>Clear Spring Health Community Advantage Plan (HMO)</b> provides up to 20 meals, up to 28 days after each discharge; meals provided through Nations Benefits.<br>\$0 copay for meals   |