Clear Spring Health

Community Care Alliance of Illinois

Eon Health

Summary of Benefits

Clear Spring Health Choice Plan (PPO)

January 1, 2021 - December 31, 2021

About Us

Eon 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.

About the Summary of Benefits

We want you to get the most from your health plan. This booklet gives you a summary of what we cover and what you, as a member - can expect to pay. Please keep in mind, however, it doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us or refer to your "Evidence of Coverage Booklet". You can also find a copy on our website, www.eonhp.com.

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 Choice Plan (PPO)).
- In a PPO plan, except in an emergency situation, if you use providers that are not in our network, your costs may be higher.

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.

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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

Clear Spring Health has a contract with Medicare to offer PPO, HMO, and PDP Plans. Eon Health has a contract with the Georgia Medicaid program and a contract with the South Carolina Medicaid program. Enrollment in these plans depends on contract renewal.

Things to Know About the Health Care Plan	
Hours of operation	• From October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. • From April 1 – September 30, 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 (877) 364-4566 • TTY/TDD users can call 711 • If you are not a member of this plan, call toll-free (877) 364-4566 • Our website: www.eonhp.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 areas in South Carolina: Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg and Union.

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Which doctors, hospitals, and pharmacies can I use?	Clear Spring Health Choice Plan (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the cost you pay may be higher. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost sharing may be less at pharmacies with preferred cost sharing. You can see our plan's provider directory and pharmacy directory on our website (www.eonhp.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. • Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. 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.eonhp.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.

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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.
- * Services with this symbol may require approval in advance (a referral) from your Primary Care Doctor (PCP) in order for the plan to cover them.
- ❍ Services with this symbol indicate that the Part B deductible applies to this service under Original Medicare.

If you do not get a referral or 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?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$0.00
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: $7,550 for services you receive from in-network providers. $7,550 for out-of-network providers. The combined yearly limit for covered in-network and out-of-network cost is $7,550. 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?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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Benefit	Clear Spring Health Choice Plan (PPO)
Covered Medical and Hospital Benefits	
Inpatient Hospital Care ♦	The plan covers 90 days for an inpatient hospital stay. Our 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. **For In-network services:** • You pay a $285 copay per day for days 1 through 7. • You pay a $0 copay per day for days 8 through 90. **For Out-of-network services:** • You pay a $395 copay per day for days 1 through 4. • You pay $0 per day for days 5 through 90. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Outpatient Hospital Care ♦ ❍	**For In-network services:** • You pay a $250 copay per visit. **For Out-of-network services:** • You pay 20% of the cost per visit.
Doctor's Office Visits ❍	**For In-network services:** • You pay a $0 copay for a Primary care physician visit. • You pay a minimum $0 copay and maximum $45 copay per visit for Specialist visits. • You pay nothing for certain telehealth services, including: Primary Care Physician Services. **For Out-of-network services:** • You pay a $20 copay for a Primary care physician visit. • You pay a $45 copay per visit for Specialist visits.

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Benefit	Clear Spring Health Choice Plan (PPO)
Preventive Care	**For In-network services:** • You are covered for all preventive services covered under Original Medicare at zero cost sharing. • Other Medicare covered preventive services: You pay a $0 copay per visit. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **For Out-of-network services:** • You are covered for all preventive services covered under Original Medicare at zero cost sharing. • Other Medicare covered preventive service: You pay 20% of the cost.
Emergency Care ❍	• You pay a $90 copay per visit for Emergency Care. The copayment will be waived if admitted as an inpatient to the hospital within 1 day of visit. See benefit booklet for details.
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) ♦ ❍	**For In-network services:** • Diagnostic tests and procedures: You pay 20% of the cost per visit. • Lab services: You pay a $10 copay per visit. • Diagnostic radiology services (such as MRIs, CT scans): You pay a $0 minimum to a $100 maximum copay per visit. See benefit booklet for details. • Outpatient x-rays: You pay a $0 minimum to a $100 maximum copay per visit. See benefit booklet for details. • Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% of the cost per visit. **For Out-of-network services:** • Diagnostic tests and procedures: You pay 20% of the cost per visit. • Lab services: You pay a $10 copay per visit. • Diagnostic radiology services (such as MRIs, CT scans): You pay 20% of the cost per service • Outpatient x-rays: You pay 40% of the cost per service. • Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% of the cost per visit.

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Hearing Services ❍	**For In-network services:** • A Medicare-covered hearing exam to diagnose and treat hearing and balance issues: You pay a $45 copay per visit. • A routine hearing exam: You pay a $0 copay per visit and limited to one visit every year. • Hearing aid fitting/evaluations: You pay a $0 copay per visit and are limited to one visit every year. • You pay a $0 copay per hearing aid. Two (2) hearing aids are covered up to a $750 maximum benefit for both ears combined benefit every three (3) years. The maximum benefit applies to both in and out-of-network services. • Hearing aids must be purchased through NationsHearing. • You will be responsible for 100% of the cost of any amount due after the $750 maximum benefit is applied **For Out-of-network services:** • You pay 20% of the cost for Medicare covered hearing exams. • You pay 50% of the cost for non-Medicare covered hearing exams. • You pay 50% of the cost for non-Medicare covered hearing aids. (See above for benefit maximum).

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Benefit	Clear Spring Health Choice Plan (PPO)
Dental Services	**For In-network services:** Preventive dental services: • Cleaning: You pay a $0 copay per visit and are limited to one visit every six (6) months. • Dental x-ray(s): You pay a $0 copay per visit and are limited to one visit every year. • Oral exam: You pay $0 copay per visit and are limited to one visit every six (6) months. Comprehensive dental services ♦: • Medicare covered services: You pay a $50 copay per visit. • Non-Medicare covered supplemental comprehensive dental services are not covered under the plan. You pay 100% of the cost for these services. **For Out-of-network services:** • You pay 50% of the cost of Non-Medicare covered Preventive dental services. • You pay 20% of the cost of Medicare covered Comprehensive Dental services.
Vision Services ❍	**For In-network services:** • You pay $45 copay per visit for an exam to diagnose and treat diseases and conditions of the eye. • You pay a $0 copay for one (1) routine eye exam every year. 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. • Eyeglasses (frames and lenses) (one (1) pair every year): $0 copay. The plan pays a maximum of $200 every year for eyeglasses (frames and lenses) for in and out-of-network eyewear. **For Out-of-network services:** • You pay 20% of the cost for Medicare covered eye exams and eyewear. • You pay 50% of the cost for non-Medicare covered eye exams and eyewear.

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Inpatient Mental Health Care ♦	**For In-network services:** The plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. • You pay a $295 copay per day for days 1 through 5. • You pay a $0 copay per day for days 6 through 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. **For Out-of-network services:** • You pay a $395 copay per day for days 1 through 4. • You pay a $0 per day for days 5 through 90.
Outpatient Mental Health Care ❍	**For In-network services:** • Outpatient individual therapy visit: You pay a $40 copay per visit with a psychiatrist and a $40 copay with other specialists. • Outpatient group therapy visit: You pay a $30 copay per visit with a psychiatrist and a $40 copay per visit with other specialists. • Partial hospitalization visit ♦: You pay a $50 copay per day. **For Out-of-network services:** • You pay a $40 copay per visit for individual and group therapy visits. • You pay 20% of the cost per day for partial hospitalization visits ♦.
Skilled Nursing Facility (SNF) ♦ ❍	The plan covers up to 100 days in a SNF. **For In-network services:** • You pay a $0 copay per day for days 1 through 20. • You pay a $167 copay per day for days 21 through 100. **For Out-of-network services:** • You pay a $195 copay per day for days 1 through 35. • You pay a $0 copay per day for days 36 through 100. You will not be charged additional cost sharing for professional services.

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Benefit	Clear Spring Health Choice Plan (PPO)
Physical Therapy ♦ ❍	**For In-network services:** • You pay a $40 copay per visit. **For Out-of-network services:** • You pay a $40 copay per visit.
Ambulance ❍	**For In-network services:** • For each covered one-way trip by ground ambulance: You pay a $275 copay. • For each covered one-way trip by air ambulance: You pay 20% of the cost. **For Out-of-network services:** • For each covered one-way trip by ground ambulance: You pay 20% of the cost. • For each covered one-way trip by air ambulance: You pay 20% of the cost. • Authorization is required for non-emergency Medicare services ♦.
Transportation (non-emergency)	Non-emergency transportation is not covered by this plan.
Part B Drugs ♦	**For In-network services:** • For Part B drugs such as chemotherapy/radiation drugs: You pay 20% of the total cost. • Other Part B drugs: You pay 20% of the total cost. **For Out-of-network services:** • You pay 20% of the cost of covered Part B prescription drugs.
Ambulatory Surgery Center ♦	**For In-network services:** • You pay a $275 copayment per visit. **For Out-of-network services:** • You pay 20% of the cost per visit.

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Benefit	Clear Spring Health Choice Plan (PPO)
Wellness Programs	
Health Club Membership SilverSneakers® Fitness	You pay $0 copay 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.eonhp.com or call Member Services (877) 364-4566 (TTY): 711. Our hours of operation are: • From October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. • From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.
Over-the-Counter Items	**For In-network services:** • You pay a $0 copay per item up to $45 maximum benefit every three (3) months. **For Out-of-network services:** • You pay 50% of the cost per non-Medicare covered item up to a $45 maximum benefit every (3) months. Please visit our website to see our list of covered over-the-counter items.

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Benefit	Clear Spring Health Choice Plan (PPO)
Prescription Drug Benefits	
Deductible	You pay a $200 Deductible every year for Preferred Brand Drugs (Tier 3), Non-preferred Drugs (Tier 4) and Specialty Drugs (Tier 5)
Initial Coverage	You pay the following until your total yearly drug costs reach $4,130. 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. Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost sharing may be less at pharmacies with preferred cost sharing. If you reside in a long-term care facility, you pay the same as at a retail pharmacy for a one-month supply only. Medications administered as part of home infusion therapy require 20% coinsurance. You may get drugs from an out-of-network retail pharmacy at the same cost as an in-network retail pharmacy for a one-month supply only. For retail cost-sharing see table 1. For mail order cost-sharing see table 2.

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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	You pay a $0 copay per prescription	You pay a $5 copay per prescription	You pay a $0 copay per prescription	You pay a $5 copay per prescription
Tier 2 Generic	You pay a $12 copay per prescription	You pay a $17 copay per prescription	You pay a $30 copay per prescription	You pay a $42.50 copay per prescription
Tier 3 Preferred Brand	You pay a $42 copay per prescription	You pay a $47 copay per prescription	You pay a $105 copay per prescription	You pay a $117.50 copay per prescription
Tier 4 Non-Preferred Brand	You pay a $95 copay per prescription	You pay a $100 copay per prescription	You pay a $237.50 copay per prescription	You pay a $250 copay per prescription
Tier 5 Specialty	You pay 29% of the cost	You pay 29% of the cost	You pay 29% of the cost	You pay 29% of the cost

Table 2

Mail Order Cost-Sharing In-Network	Standard Mail Order 1-Month	Standard Mail Order 3-Months
Tier 1 Preferred Generic	You pay a $0 copay per prescription	You pay a $0 copay per prescription
Tier 2 Generic	You pay a $12 copay per prescription	You pay a $30 copay per prescription
Tier 3 Preferred Brand	You pay a $42 copay per prescription	You pay a $105 copay per prescription
Tier 4 Non-Preferred Brand	You pay a $95 copay per prescription	You pay a $237.50 copay per prescription
Tier 5 Specialty	You pay 29% of the cost	You pay 29% of the cost

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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 $4,130. You pay 25% of the cost for generic drugs and 25% of the cost of brand-name drugs until your costs total $6,550, 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for generic (including brand drugs treated as generic) and $9.20 for all other drugs.
Other Care and Services	
Remote Access Technology (Web/Phone-Based Technologies)	A WIFI enabled tablet pre-loaded with software applications primarily focused on allowing you conduct telehealth visits, access educational content, basic benefit information and to facilitate engagement with Clear Spring Health will be made available to any member that chooses to participate in a no cost Health Risk Assessment. A 24 hours a day, 7 days a week nursing hotline is available.
Chiropractic Care ♦ ❍	**For In-network services:** • 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 a $20 copay per visit. • Routine chiropractic services: You pay a $20 copay per visit for up to four (4) visits every year. Authorization will be required after the first four visits every year. **For Out-of-network services:** • You pay 20% of the cost of Medicare covered services. • You pay 50% of the cost of non-Medicare covered services (routine/other care)

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Home Health Care ♦	**For In-network services:** • You pay a $0 copay per visit. **For Out-of-network services:** • You pay 20% of the cost of covered 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.) ♦ ❍	**For In-network services:** • Prosthetic devices: You pay 20% of the cost of covered items. • Related medical supplies: You pay 20% of cost of covered items. **For Out-of-network services:** • You pay 20% of the cost of covered items.
Renal Dialysis ❍	**For In-network services:** • You pay 20% of the cost of covered services. **For Out-of-network services:** • You pay 20% of the cost of covered services.