2024 SUMMARY OF BENEFITS

SOUTH CAROLINA, GEORGIA
VIRGINIA

Clear Spring Health

H2334-005 Clear Spring Health Gold Plus (PPO)
South Carolina
COUNTIES: Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg, Union

H9589-003 Clear Spring Health Choice Plan (PPO)
Georgia
COUNTIES: Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Candler, Chatham, Chattahoochee, Cherokee, Clarke, Clayton, Clinch, Cobb, Coweta, Crawford, Dawson, DeKalb, Dodge, Dooly, Douglas, Elbert, Emanuel, Evans, Fannin, Fayette, Forsyth, Franklin, Fulton, Gilmer, Glascock, Greene, Gwinnett, Habersham, Hall, Hancock, Haralson, Harris, Hart, Heard, Henry, Houston, Irwin, Jackson, Jasper, Jefferson, Jenkins, Johnson, Jones, Lamar, Lincoln, Long, Lumpkin, Macon, Madison, Marion, McIntosh, Meriwether, Monroe, Montgomery, Morgan, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pike, Polk, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Spalding, Stevens, Talbot, Taliaferro, Tattnall, Taylor, Telfair, Towns, Treutlen, Turner, Twiggs, Union, Upson, Walton, Warren, Washington, Webster, Wheeler, White, Wilcox, Wilkes, Wilkinson

H8014-002 Clear Spring Health Essential (PPO)
Virginia
COUNTIES: Chesterfield, Colonial Heights City, Hanover, Henrico, Hopewell City, Petersburg City, Richmond City

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 Gold Plus (PPO), Clear Spring Health Choice Plan (PPO), or Clear Spring Health Essential (PPO)** 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. 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

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
	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)*	$6,500 **Combined MOOP In and Out of Network** $10,000	$6,700 **Combined MOOP In and Out of Network** $10,000	$4,950 **Combined MOOP In and Out of Network** $8,950
Inpatient Hospital Coverage Acute (+)	**In-Network** $295 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-Network** $395 copay per day for days 1-4; $0 copay per day for days 5-90	**In-Network** $295 copay per day for days 1-7; $0 copay per day for days 8-90 **Out-of-Network** $395 copay per day for days 1-7; $0 copay per day for days 8-90	**In-Network** $295 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-Network** 45% of the total cost per day for days 1-5; 0% of the total cost per day for days 6-90
Inpatient Hospital Coverage – Psychiatric (+)	**In-Network** $295 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-Network** $395 copay per day for days 1-4; $0 copay per day for days 5-90	**In-Network** $250 copay per day for days 1-7; $0 copay per day for days 8-90 **Out-of-Network** $395 copay per day for days 1-7; $0 copay per day for days 8-90	**In-Network** $295 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-Network** 45% of the total cost per day for days 1-90

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
Outpatient Hospital Coverage (+)	**In-Network** $250 copay **Out-of-Network** 20% of the total cost	**In-Network** $250 copay **Out-of-Network** 20% of the total cost	**In-Network** $45 to $300 copay $45 copayment for some skin tag removals performed at a dermatologist's office. $300 copayment for all other services. **Out-of-Network** 45% of the total cost
Ambulatory Surgical Center (ASC) Services (+)	**In-Network** $200 copay **Out-of-Network** 20% of the total cost	**In-Network** $200 copay **Out-of-Network** 20% of the total cost	**In-Network** $45 to $250 copay $45 copayment for some skin tag removals performed at a dermatologist's office. $250 copayment for all other services. **Out-of-Network** 45% of the total cost
Doctor Visits (Primary Care Providers and Specialists) (+)	**In-Network** $0 copay for primary care visits **Out-of-Network** 20% of the total cost for primary care visits **In-Network** $0 to $45 copay for specialist visits $0 copay for Endocrinologist Specialist. $45 copay for all other Specialists. **Out-of-Network** $50 copay for specialist	**In-Network** $0 copay for primary care visits **Out-of-Network** 45% of the total cost for primary care visits **In-Network** $0 to $45 copay for specialist visits $0 copay for Endocrinologist Specialist. $45 copay for all other Specialists. **Out-of-Network** $50 copay for specialist	**In-Network** $0 copay for primary care visits **Out-of-Network** 45% of the total cost for primary care visits **In-Network** $0 to $40 copay for specialist visits $0 copay for Endocrinologist Specialist. $40 copay for all other Specialists. **Out-of-Network** 45% of the total cost for

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
	visits	visits	specialist visits
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	**In-Network** $0 copay **Out-of-Network** 20% of the total cost	**In-Network** $0 copay **Out-of-Network** 45% of the total cost	**In-Network** $0 copay **Out-of-Network** 45% of the total cost
Emergency Care	**In-Network** $90 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. **Out-of-Network** $90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition.	**In-Network** $90 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. **Out-of-Network** $90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition.	**In-Network** $90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition. **Out-of-Network** $90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition.
Urgently Needed Services	$35 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	$35 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	$40 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.
Diagnostic Services/Labs/Imaging	**In-Network** 20% of the total cost for diagnostic procedures and tests $10 copay for lab	**In-Network** 20% of the total cost for diagnostic procedures and tests	**In-Network** $25 copay for diagnostic procedures and tests $25 copay for lab services

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
Diagnostic tests and procedures Lab Services Diagnostic radiology Outpatient x-rays (+)	services $0 to $100 copay for x-rays **Out-of-Network** 20% of the total cost for diagnostic procedures 20% of the total cost for lab services 40% of the total cost for x-rays	$0 copay for lab services $0 to $100 copay for x-rays **Out-of-Network** 20% of the total cost for diagnostic procedures 45% of the total cost for lab services 40% of the total cost for x-rays	$45 copay for x-rays **Out-of-Network** 45% of the total cost for diagnostic procedures 45% of the total cost for lab services 45% of the total cost for x-rays
Hearing Services Routine Hearing Exam Hearing Aids	**In-Network** $50 copay for Medicare-covered hearing exams **Out-of-Network** 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.	**In-Network** $50 copay for Medicare-covered hearing exams **Out-of-Network** 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.	**In-Network** $45 copay for Medicare-covered hearing exams **Out-of-Network** 45% 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.

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
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 in- and out-of-network non-Medicare-covered comprehensive dental services. **Out-of-Network** $0 copay for listed services up (up to maximum amount for comprehensive benefits)	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 in- and out-of-network non-Medicare-covered comprehensive dental services. **Out-of-Network** $0 copay for listed services up (up to maximum amount for comprehensive benefits)	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 in- and out-of-network non-Medicare-covered comprehensive dental services. **Out-of-Network** $0 copay for listed services up (up to maximum amount for comprehensive benefits)
Vision Services	**In-Network** $50 copay for Medicare-covered eye exam **Out-of-Network** 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 $200 maximum plan	**In-Network** $50 copay for Medicare-covered eye exam **Out-of-Network** 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 $200 maximum plan	**In-Network** $45 copay for Medicare-covered eye exam **Out-of-Network** 45% of the total cost for Medicare-covered eye exam 1 routine vision exam every year at $0 copay 1 pair of eyeglasses every year $150 maximum plan

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
	coverage amount for all non-Medicare-covered eyewear. **Out-of-Network** $0 copay for routine eye exam Eyeglasses: 20% of the total cost for Medicare-covered eyewear	coverage amount for all non-Medicare-covered eyewear. **Out-of-Network** $0 copay for routine eye exam Eyeglasses: 20% of the total cost Medicare-covered eyewear	coverage amount for all non-Medicare-covered eyewear. **Out-of-Network** $0 copay for routine eye exam Eyeglasses: 45% of the total cost Medicare-covered eyewear
Mental Health Services	**In-Network** $40 copay for individual sessions **Out-of-Network** 20% of the total cost for individual sessions **In-Network** $40 copay for group sessions **Out-of-Network** 20% of the total cost for group sessions	**In-Network** $40 copay for individual sessions **Out-of-Network** $40 to $40 copay for individual sessions **In-Network** $40 copay for group sessions **Out-of-Network** $40 to $40 copay for group sessions	**In-Network** $40 copay for individual sessions **Out-of-Network** 45% of the total cost for individual sessions **In-Network** $40 copay for group sessions **Out-of-Network** 45% of the total cost for group sessions

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
Skilled Nursing Facility (+)	**In-Network** $0 copay per day for days 1-20; $160 copay per day for days 21-100 **Out-of-Network** $195 copay per day for days 1-35; $0 copay per day for days 36-100	**In-Network** $0 copay per day for days 1 -20; $160 copay per day for days 21-62; $0 copay per day for days 63-100 **Out-of-Network** $195 copay per day for days 1-35; $0 copay per day for days 36-100	**In-Network** $0 copay per day for days 1-20; $178 copay per day for days 21-100 **Out-of-Network** 45% of the total cost per day for days 1-20; 45% of the total cost per day for days 21-100
Physical Therapy (+)	**In-Network** $40 copay **Out-of-Network** 20% of the total cost	**In-Network** $40 copay **Out-of-Network** 45% of the total cost	**In-Network** $40 copay **Out-of-Network** 45% of the total cost

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
Ambulance (+)	**In-Network** $275 copay for ground ambulance transportation **Out-of-Network** 20% of the total cost for ground ambulance transportation **In-Network** 20% of the total cost for air transportation **Out-of-Network** 20% of the total cost for air transportation	**In-Network** $275 copay for ground ambulance transportation **Out-of-Network** 20% of the total cost for ground ambulance transportation **In-Network** 20% of the total cost for air transportation **Out-of-Network** 20% of the total cost for air transportation	**In-Network** $270 copay for ground ambulance transportation **Out-of-Network** $275 to $275 copay for ground ambulance transportation **In-Network** $270 copay for air transportation **Out-of-Network** $275 copay for air transportation
Transportation (+)	**In-Network** up to 12 round trips every year to plan-approved health-related locations. **Out-of-Network** Not covered	**In-Network** up to 12 round trips every year to plan-approved health-related locations. **Out-of-Network** Not covered	**In-Network** up to 12 round trips every year to plan-approved health-related locations. **Out-of-Network** Not covered
Medicare Part B Drugs	**In-Network** $35 copay for Insulin	**In-Network** $35 copay for Insulin	**In-Network** $35 copay for Insulin

	H2334-005 Clear Spring Health Gold Plus (PPO) SC	H9589-003 Clear Spring Health Choice Plan (PPO) GA	H8014-002 Clear Spring Health Essential (PPO) VA
	Out-of-Network 20% of the total cost for Insulin **In-Network** 20% of the total cost for Chemotherapy **Out-of-Network** 20% of the total cost for Chemotherapy **In-Network** 20% of the total cost for Other Part B drugs **Out-of-Network** 20% of the total cost for Other Part B drugs	**Out-of-Network** 20% of the total cost for Insulin **In-Network** 20% of the total cost for Chemotherapy **Out-of-Network** 20% of the total cost for Chemotherapy **In-Network** 20% of the total cost for Other Part B drugs **Out-of-Network** 20% of the total cost for Other Part B drugs	**Out-of-Network** 45% of the total cost for Insulin **In-Network** 20% of the total cost for Chemotherapy **Out-of-Network** 45% of the total cost for Chemotherapy **In-Network** 20% of the total cost for Other Part B drugs **Out-of-Network** 45% of the total cost for Other Part B drugs

	PRESCRIPTION DRUGS H2334-005 Clear Spring Health Gold Plus (PPO) SC
Stage 1: Deductible Stage	**$200** 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 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 copay	$5 copay	$0 copay	$5 copay	$0 copay
Tier 2: Generic	$0 copay	$17 copay	$0 copay	$42.50 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 **H9589-003 Clear Spring Health Choice Plan (PPO)** **GA**
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 plan does not provide an 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	$17 copay	$0 copay	$42.50 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 H8014-002 Clear Spring Health Essential (PPO) VA
Stage 1: Deductible Stage	**$0**
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 an 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	$9 copay	$0 copay	$27 copay	$0 copay
Tier 2: Generic	$0 copay	$12 copay	$0 copay	$36 copay	$0 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay	$141 copay	$42 copay
Tier 4: Non-Preferred Drug	$95 copay	$100 copay	$285 copay	$300 copay	$95 copay
Tier 5: Specialty	33% of the total cost	33% 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.	33% of the total cost

	H2334-005 Clear Spring Health Gold Plus (PPO)	**H9589-003 Clear Spring Health Choice Plan (PPO)**	**H8014-002 Clear Spring Health Essential (PPO)**
	ADDITIONAL BENEFITS		
Over the Counter	$85 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. **Out-of-Network**	$85 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. **Out-of-Network**	$95 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. **Out-of-Network**

	H2334-005 Clear Spring Health Gold Plus (PPO)	H9589-003 Clear Spring Health Choice Plan (PPO)	H8014-002 Clear Spring Health Essential (PPO)
	Not covered	Not covered	Not covered
Special Supplemental Benefits for the Chronically Ill	**$125** 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.	**$125** 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.	**$125** 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.