2021
Summary of Benefits

RiverSpring Star

(HMO I-SNP)

For more information, call us **1-800-580-7000** (TTY 711)
8 a.m. to 8 p.m. ET – 7 days a week.

www.RiverSpringHealthPlans.org

H6776_SOB001CY21_M File and Use 09/15/2020

RiverSpring Star (HMO I-SNP)

Summary of Benefits

January 1, 2021 – December 31, 2021

This is a summary of drug and health services covered by **RiverSpring Star (HMO I-SNP)** January 1, 2021 – December 31, 2021.

RiverSpring Star is an (HMO I-SNP) plan with a Medicare contract. Enrollment in RiverSpring Star (HMO I-SNP) depends on contract renewal.

To join **RiverSpring Star (HMO I-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and live in a nursing home or at home but require the same level of care as those who live in a nursing home.

Our service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Queens, Richmond, and Westchester.

RiverSpring Star (HMO I-SNP) 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.

Out-of-network/non-contracted providers are under no obligation to treat RiverSpring Star (HMO I-SNP) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The benefit information provided is a summary of what we cover and what you pay. It does not list every single service that we cover or list every limitation or exclusion. To get a complete list of services we cover, you can visit our website and refer to the "Evidence of Coverage" or you can call us and request the "Evidence of Coverage."

This information is not a complete description of benefits. Call 1-800-580-7000 (TTY/TDD 711) for more information.

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RiverSpring Star (HMO I-SNP): Summary of Benefits

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$42.30 per month for your Part D premium. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. $445 per year for Part D prescription Drugs. *$203* per year for Part B Deductible for in-network services.
Is there any limit on how much I will pay for my covered services?	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. 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.
Premiums and Benefits	
Note: • Services with a [1] may require prior authorization. • Services with a [2] may require a referral from your doctor.	
Inpatient Hospital Coverage[1] ***(continued on next page)***	A per admission deductible is applied once during the defined benefit period. In 2021, the amounts for each benefit period are: • $1,484 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $371 copay per day • Days 91 and beyond: $742 copay per day for each “lifetime reserve day” for each benefit period • Beyond lifetime reserve days, you pay all costs

Inpatient Hospital Coverage[1] (*continued from previous page)*	Authorization is required 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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.
Outpatient Hospital Services[1]	20% of the cost – Authorization is required
Doctor's Office Visits	Primary care physician visit: 20% of the cost Specialist visit: 20% of the cost – Authorization is required
Preventive Care ***(continued on next page)***	$0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Multi-target stool DNA test, Screening barium enemas, Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma test • Hepatitis B Virus (HBV) infection screening • Hepatitis C screening test • HIV screening • Lung Cancer screening • Mammograms (screening) • Nutrition therapy services • Obesity screening and counseling

Preventive Care ***(continued from previous page)***	• One-time “Welcome to Medicare” preventive visit • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	20% of the cost (up to $90) for each visit. If you are admitted to the hospital within 3 days, 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.
Urgently Needed Services	20% of the cost (up to $65) for each visit. If you are admitted to the hospital within 3 days, 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.
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different in an outpatient surgery setting)*	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost and Authorization is required Diagnostic tests and procedures: 20% of the cost Lab services: 20% of the cost Authorization is not required Outpatient x-rays: 20% of the cost and Authorization is required Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Authorization is required
Hearing Services [1]	Exam to diagnose and treat hearing and balance issues: 20% of the cost Authorization is required
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): 20% of the cost Authorization is required
Vision Services[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost and Authorization is required

	Eyeglasses or contact lenses after cataract surgery: 20% of the cost and Authorization is not required
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. 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. In 2021 the amounts for each benefit period are: • $1,484 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $371 copay per day • Days 91 and beyond: $742 copay per day for each “lifetime reserve day” for each benefit period. • Beyond lifetime reserve days, you pay all costs Outpatient group therapy visit: 20% of the cost Outpatient individual therapy visit: 20% of the cost Authorization is required
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In 2021 the amounts for each benefit period are: • Days 1-20: $0 copay for each benefit period • Days 21-100: $185 copay per day • Days 101 and beyond: you pay all costs Authorization is required

Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Intensive Cardiac Rehabilitation Services (for a maximum of 6 one-hour sessions per day for up to 72 sessions – these sessions must occur during an 18 week period) : 20% of the cost Pulmonary Rehabilitation Services: 20% of the cost Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services : 20% of the cost Occupational therapy (OT) visit: 20% of the cost Physical Therapy (PT) and Speech and Language Therapy visit: 20% of the cost Authorization is required
Ambulance[1]	20% of the cost Authorization is required
Ambulatory Surgery Center (ASC)[1]	20% of the cost Authorization is required
Transportation	Not covered
Medicare Part B Drugs[1]	For Part B drugs such as chemotherapy/radiation drugs: 20% of the cost Other Part B Drugs: 20% of the cost Authorization is required
Foot Care *(podiatry services)*[1]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost Authorization is required
Durable Medical Equipment *(wheelchairs, oxygen, etc.)1*	20% of the cost Authorization is required for each DME item that cost $250 or more.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost Authorization is required

Diabetes Supplies and Services[1]	Diabetes monitoring supplies: 20% of the cost Authorization is required Diabetes self-management training: 20% of the cost Therapeutic shoes or inserts: 20% of the cost Authorization is required
Wellness Programs *(fitness programs)*	Not covered.

Optional Supplemental Benefits	
RiverSpring Star (HMO I-SNP) plan offers supplemental benefits in addition to Part C benefits and Part D benefits. A summary of the supplemental benefits are listed below:	
Over-the-Counter Supplies Benefit	Our plan covers over-the-counter items up to $170.00 per month. You have two ways to obtain eligible OTC items: • Using an OTC card provided by RiverSpring at any participating pharmacy, or • Ordering OTC items from a catalog provided by RiverSpring Any unused portions will not be rolled over from one month to the next. The OTC balance does not roll over from year to year. The OTC items covered may be purchased for the member only. This benefit cannot be converted to cash. There is no cost to you for this benefit.

Prescription Drug Benefits

Initial Coverage	After you pay your yearly deductible, depending on your income and institutional status, you pay 25% coinsurance of the cost for all drugs covered by this plan 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. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
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. 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 $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 an $9.20 copay for all other drugs.

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 http://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 http://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.

RiverSpring Star (HMO I-SNP) Phone Numbers and Website

- Call toll-free 1-800-580-7000 or TTY users should call 711.

- You can find all plan materials, including the Provider and Pharmacy Directory at www.RiverSpringHealth Plans.org
- You can also see the complete list of covered drugs (Formulary) on our website listed above.
- Or, call us and we will send you a copy of our plan materials.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET.

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This information is not a complete description of benefits. Call 1-800-580-7000 or TTY/TDD 711 for more information.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-800-580-7000.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-580-7000 (TTY/TDD 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.RiverSpringStar.org or call 1-800-580-7000 (TTY/TDD 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding 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.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.

Notice of Non-Discrimination

ElderServe Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ElderServe Health, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ElderServe Health, Inc:

- 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, contact Civil Rights Coordinator. If you believe that ElderServe Health, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Civil Rights Coordinator
80 West 225th Street
Bronx, NY, 10463
Phone: 1-347-842-3660, TTY 711
Fax: 1-888-341-5009

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You may 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, D.C. 20211
1-800-368-1019, 1-800-537-7697 (TDD)

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

RiverSpring Star (HMO I-SNP): Summary of Benefits

Multi-Language Insert

English: ATTENTION: If you speak non-English language or require assistance, language assistance services free of charge, are available to you. Call 1-800-580-7000 (TTY/TDD 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-580-7000 (TTY/TDD 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-580-7000（TTY/TDD 711)

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-580-7000 (TTY/TDD 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-580-7000 (TTY/TDD 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-580-7000 (TTY/TDD 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-580-7000 (TTY/TDD 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-580-7000 (TTY/TDD 711).번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-580-7000 (телетайп: TTY/TDD 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-800-580-7000) رقم (711) والبكم: هاتف الصم

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-580-7000 (TTY/TDD 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-580-7000 (TTY/TDD 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-580-7000 (TTY/TDD 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-580-7000 (TTY/TDD 711).

Hindi: ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-580-7000 (TTY/TDD 711). पर कॉल कर।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1-800-580-7000 (TTY/TDD 711) まで、お電話にてご連絡ください。

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