2025

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_SB001CY25_M

RiverSpring Star (HMO I-SNP)

Summary of Benefits

January 1, 2025 – December 31, 2025

This is a summary of drug and health services covered by **RiverSpring Star (HMO I-SNP)** January 1, 2025 – December 31, 2025.

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 www.RiverSpringHealthPlans.org 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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Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$26.30 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. $590 per year for Part D prescription Drugs. $240 per year for Part B Deductible for in-network services, except for insulin furnished through an item of durable medical equipment. *These amounts may change in 2025. New rates will be provided to you as they become available from Medicare.*
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: • $9,350 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 2025, the amounts for each benefit period are: • $0 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $0 copay per day • Days 91 and beyond: $0 copay per day for each “lifetime reserve day” for each benefit period • Beyond lifetime reserve days, we will 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 are admitted as an inpatient and ends when you have not 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 is no limit to the number of benefit periods.
Outpatient Hospital Services[1]	20% of the cost – Authorization is required
Ambulatory Surgical Center (ASC) services	20% of the cost – Authorization is **not** required
Doctor's Office Visits	Primary care physician visit: $0 per visit Specialist visit: 20% of the cost – Only the first 3 visits will not require a prior authorization. An authorization is required for all subsequent visits.
Preventative Care *(continued on next page)*	$0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual Wellness Visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (Screening barium enemas, Colonoscopy, Fecal immunochemical test (FIT), Guaiac-based fecal occult blood test (gFOBT), Flexible sigmoidoscopy) • Depression screening • Diabetes screenings; Diabetes self-management training, diabetic services and supplies

Preventive Care ***(continued from previous page)***	• Vision Care (Glaucoma screening, diabetic retinopathy screening, diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration)Hepatitis C screening test • HIV screening • Immunizations (Flu shots, Pneumonia vaccine, Hepatitis B vaccines, COVID-19 vaccine) • Lung Cancer screening with low dose computed tomography (LDCT) • Medical Nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • One-time "Welcome to Medicare" preventive visit • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	20% of the cost (up to $110) 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 $45) 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 Authorization is required for MRI and PET scans Diagnostic tests and procedures: 20% of the cost Lab services: 20% of the cost Outpatient x-rays: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Routine Lab Services do **not** require an authorization. Some Lab Services might require an authorization.

Hearing Services [1]	Exam to diagnose and treat hearing and balance issues: 20% of the cost Diagnostic hearing and balance evaluations are limited to one per year without prior authorization. All subsequent evaluations will require a prior authorization.
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 Diagnostic evaluation for the treatment of diseases and injuries of the eye are limited to one per year without prior authorization. Any subsequent evaluations will require a prior authorization. Eyeglasses or contact lenses after cataract surgery: 20% of the cost and Authorization is **not** required
Mental Health Care[1] **(continued on next page)**	Inpatient Hospital Psychiatric Services: 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 are admitted as an inpatient and ends when you have not 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 is 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 2025 the amounts for each benefit period are: • $0 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $0 copay per day • Days 91 and beyond: $0 copay per day for each “lifetime reserve day” for each benefit period. • Beyond lifetime reserve days, we pay all costs

Mental Health Care[1] **(continued)**	Outpatient Psychiatric Services: 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 2025 the amounts for each benefit period are: • Days 1-20: $0 copay for each benefit period • Days 21-100: $0 copay per day • Days 101 and beyond: you pay all costs Authorization is required
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services : 20% of the cost Intensive Cardiac Rehabilitation Services: 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 for non-emergency services
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. You will not pay more than the co-insurance amount for Chemotherapy administration services including chemotherapy/radiation drugs or Other drugs covered under Part B of original Medicare.
What You Pay for Vaccines:	Our plan covers most Part D vaccines at no cost to you even if you haven't paid your deductible. Call Member Services for more information.
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, even if you haven't paid your deductible.
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 If you have a diabetes diagnosis, an authorization will be required after six (6) visits to a podiatrist. If you do not have a diabetes diagnosis, an authorization will be required after the fourth (4^{th}) visit to a podiatrist.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	20% of the cost An authorization is required for DME equipment (non-disposable items that have a useful shelf life of over 1 year) with cost of $500 or more An authorization is required for DME supplies (disposable items that do not have a useful shelf life of over 1 year) with cost of $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] **(continued on next page)**	Diabetes monitoring supplies: $0 We cover specific manufacturers for diabetic supplies and services: From Abbott and LifeScan Authorization is required

Diabetes Supplies and Services[1] **(continued)**	Diabetes self-management training: 20% of the cost Authorization is **not** required 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 (OTC) Supplies Benefit	Our plan covers over-the-counter items up to $150.00 per month. You have two ways to obtain eligible OTC items: • Using an OTC card provided by RiverSpring at any participating location, or • Ordering OTC items by placing an order online through an online catalog Any unused portions will not roll over from month to month. 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.
Over-the-Counter (OTC) Plus Grocery Benefit	For eligible members (with certain chronic conditions) the Special Supplemental Benefits for Chronically Ill (grocery benefit) combines with the OTC benefit to cover certain grocery items as part of the monthly OTC allowance, which may only be purchased at select pharmacies and/or retailers. You are allowed to spend 50% ($75.00) of the OTC benefit amount towards food and produce. The benefits mentioned are a part of special supplemental program for the chronically ill. Some examples of conditions include *Cardiovascular Disorder, Hypertension, Osteoarthritis, Endocrine Disorder and Gastrointestinal Disorder*. Eligibility for this benefit cannot be guaranteed based solely on your condition. Eligible members will be notified and provided instructions on how to access this benefit

Prescription Drug Benefits	
Part D Annual out of Pocket (TrOOP or RxMOOP)	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 $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Tier 1: 25% coinsurance 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.
Catastrophic Coverage	Once you reach the annual out of pocket threshold of $2,000 you enter the Catastrophic Coverage phase. This means you will have no cost-sharing for Medicare Part D Formulary 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.

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

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

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

- ☐ The Evidence of Coverage (EOC), provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. 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.
- ☐ Review the formulary to make sure your drugs are covered.

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, 2025.
- ☐ 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 skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.
- ☐ Effect on Current Coverage

Notice of Non-Discrimination

ElderServe Health, Inc. d/b/a RiverSpring Health Plans 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. d/b/a RiverSpring Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ElderServe Health, Inc. d/b/a RiverSpring Health Plans.:

- 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

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-580-7000. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-580-7000. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-580-7000。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-580-7000。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-580-7000. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-580-7000. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-580-7000 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-580-7000. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-580-7000번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-580-7000. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك بمساعدتك. هذه خدمة مجانية سوى الاتصال بنا على 1-800-580-7000. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-580-7000 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-580-7000. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-580-7000. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-580-7000. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-580-7000. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-580-7000にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

RiverSpring Health Plans

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8 a.m. to 8 p.m. ET– 7 days a week.

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