2026
SUMMARY OF BENEFITS

Clear Spring Health

Illinois

Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005
Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006

SUMMARY OF BENEFITS

Clear Spring Health

This is a summary of health and drug services covered by Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) from January 1, 2026 – December 31, 2026.

Clear Spring Health has a contract with Medicare to offer HMO and PPO Plans. 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 2026 "Evidence of Coverage," or call 1-877-364-4566 to request a copy of the Evidence of Coverage to be mailed to you. TTY users should call 711. The Evidence of Coverage will be available on our website by no later than October 15, 2025.

To join Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005 or Clear Spring Health Balance + Diabetes & Heart (HMO C-SNP) H5454-006**,** you must be entitled to Medicare Part A, be enrolled in Medicare B, and live in our service area. To join Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP), you must be diagnosed with Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes Mellitus. Our service area includes the following counties in Illinois:

For H5454-005:
Boone, Clinton, Macoupin, Madison, Ogle, St. Clair, Stephenson, Winnebago.

For H5454-006:
Cook, DuPage, Kane, Kankakee, LaSalle, McHenry, Will.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4277). TTY users should call 1-877-486-2048.

Call us or go online for more information.

Not a member yet? Call 1-877-248-6622 (TTY: 711)
From October 1st – March 31st, you can call us 7 days a week from 8:00am to 8:00pm. From April 1st – September 30th, you can call us Monday through Friday from 8:00am – 8:00pm

Already a member? Call 1-877-364-4566 (TTY:711)
From October 1st – March 31st, you can call us 7 days a week from 8:00am to 8:00pm. From April 1st – September 30th, you can call us Monday through Friday from 8:00am – 8:00pm

Website: clearspringhealthcare.com

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.clearspringhealthcare.com** or call **1-877-364-4566 (TTY: 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.

- 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 with a **(!)** indicate a prior authorization may be required.

Understanding Important Rules

- 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 January 1, 2027.

	Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005	Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium	
Part B Reduction	$0	$2.10
Deductible (Part C-Medical)	$0	$0
Maximum Out-of-Pocket	$6,751	$6,751
Inpatient Hospital Coverage – Acute (!)	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90
Inpatient Hospital Coverage – Psychiatric (!)	$290 copay per day for days 1-5; $0 copay per day for days 6-90	$290 copay per day for days 1-5; $0 copay per day for days 6-90

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Outpatient Hospital Coverage (!)	$225 copay Authorization required for Medicare-covered observation services after the first 24 hours.	$225 copay Authorization required for Medicare-covered observation services after the first 24 hours.
Ambulatory Surgical Center (ASC) Services (!)	$200 copay	$200 copay
Doctor Visits (Primary Care Providers and Specialists)	Primary Care: $0 copay Specialist: $0 to $25 copay $0 copay for endocrinologist. $25 copay for all other specialists.	Primary Care: $0 copay Specialist: $0 to $25 copay $0 copay for endocrinologist. $25 copay for all other specialists.
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	$0 copay for preventive care.	
Emergency Care	$115 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	$115 copay ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.
Urgently Needed Services	$40 copay	$40 copay

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	Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.
Diagnostic Services/Labs/Imaging (!) Diagnostic tests and procedures Lab Services Diagnostic radiology Outpatient X-rays	Diagnostic Tests and procedures: $0 copay Lab Services: $5 copay Diagnostic Radiology: $20 to $175 copay. $20 copayment for diagnostic ultrasound and diagnostic bone density imaging. $175 copayment for all other diagnostic radiological services (e.g., CT, MRI). X-rays: $25 copay.	Diagnostic Tests and procedures: $0 copay Lab Services: $5 copay Diagnostic Radiology: $20 to $175 copay. $20 copayment for diagnostic ultrasound and diagnostic bone density imaging. $175 copayment for all other diagnostic radiological services (e.g., CT, MRI). X-rays: $25 copay.
Hearing Services	Medicare Covered Hearing Exam: $30 copay	Medicare Covered Hearing Exam: $30 copay

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Routine Hearing Exam Hearing Aids	Routine Hearing Exam: 1 exam every year. $0 copay. Hearing aids: $500 maximum plan coverage amount every year (per ear) for prescription hearing aids. Hearing aids must be purchased through NationsHearing in order to access the benefit.	Routine Hearing Exam: 1 exam every year. $0 copay. Hearing aids: $500 maximum plan coverage amount every year (per ear) for prescription hearing aids. Hearing aids must be purchased through NationsHearing in order to access the benefit.
Dental Services	Medicare Covered Dental Services: $30 copay	Medicare Covered Dental Services: $30 copay
	Non-Medicare Covered Dental Services: Preventive Services: $0 copay Comprehensive Services: $0 copay.$2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. Refer to the EOC Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered.	Non-Medicare Covered Dental Services: Preventive Services: $0 copay Comprehensive Services: $0 copay.$2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. Refer to the Evidence of Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered.

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Vision Services	Medicare Eye Exam Services: $30 copay	Medicare Eye Exam Services: $30 copay
	Routine Eye Exam: 1 exam every year $0 copay for routine eye exam. $250 maximum plan coverage amount every year for all non-Medicare-covered eyewear.	Routine Eye Exam: 1 exam every year $0 copay for routine eye exam. $250 maximum plan coverage amount every year for all non-Medicare-covered eyewear.
Mental Health Services	Mental Health (Individual sessions): $30 copay Mental Health (Group sessions): $30 copay	Mental Health (Individual sessions): $30 copay Mental Health (Group sessions): $30 copay
Skilled Nursing Facility (!)	$0 copay per day for days 1-20; $167 copay per day for days 21-100	$0 copay per day for days 1-20; $167 copay per day for days 21-100
Physical & Speech Therapy (!)	$40 copay	$40 copay
Ambulance (!)	Ground: $275 copay Air: $275 copay	Ground: $275 copay Air: $275 copay

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Medicare Part B Drugs (!)	0% to 20% of the total cost. The 0% coinsurance applies to drugs covered under the Inflation Reduction Act. The 20% cost sharing applies to all other Medicare Part B drugs not covered under the Inflation Reduction Act. For a list of drugs covered at 0% cost sharing under the Inflation Reduction Act, visit https://www.cms.gov/files/document/reduced-coinsurance-certain-part-b-rebatable-drugs-july-1-september-30-2024.pdf	
Transportation	12 one-way trips every year to plan-approved health-related locations. Prior authorization needed for rides over 25 miles. Transportation administered and managed by our partner Kaizen Health.	
Grocery Benefit	$50 every month. Amount does not carry over to next month. A health risk assessment (HRA) must be submitted and verified through other data sources. Must have one of the qualifying chronic illnesses which are diabetes, chronic heart failure, or cardiovascular disease. Refer to the EOC for full details.	$60 every month. Amount does not carry over to next month. A health risk assessment (HRA) must be submitted and verified through other data sources. Must have one of the qualifying chronic illnesses which are diabetes, chronic heart failure, or cardiovascular disease. Refer to the EOC for full details.
Over-the-Counter Benefit	$50 maximum plan coverage amount every month for OTC items. Unused portion does not carry over to the next period.	$50 maximum plan coverage amount every month for OTC items. Unused portion does not carry over to the next period.

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Better Health 4 You (Rewards & Incentives)	Visit www.clearspringhealthcare.com to learn more about the Better Health 4 You program. The Better Health 4 Your program is offered to all members at no cost. Get rewarded for actively participating in health screenings.	
SilverSneakers	SilverSneakers membership is available at no cost while a member of the plan. Any services not included in a basic membership may require additional fees.	

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	PRESCRIPTION DRUGS Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005				
Deductible	$100 Applies to: Tier 3, Tier 4, Tier 5 You pay 100% of the covered prescription drug costs until the deductible is met. After you meet your deductible, you will pay a consistent 25% of the cost of your covered drugs until you reach the out-of-pocket maximum.				
Maximum out-of-pocket (MOOP)	$2,100 Out-of-Pocket Maximum: Your total out-of-pocket costs for prescription drugs will be capped at $2,100 per year. Once you reach this cap, you will not have to pay any more out-of-pocket costs for your prescription drugs for the remainder of the year.				
Pharmacy Type	**Preferred Retail 30-day supply**	**Non-Preferred Retail 30-day supply**	**Preferred Retail 90-day supply**	**Non-Preferred Retail 90-day supply**	**Preferred Mail Order 30-day supply**
Tier 1: Preferred Generic	$0 copay	$5 copay	$0 copay	$15 copay	$0 copay
Tier 2: Generic	$5 copay	$10 copay	$15 copay	$30 copay	$0 copay
Tier 3: Preferred Brand	20% of the total cost	20% of the total cost	20% of the total cost	20% of the total cost	20% of the total cost

	PRESCRIPTION DRUGS Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-005				
Tier 4: Non-Preferred Drug	34% of the total cost	34% of the total cost	34% of the total cost	34% of the total cost	34% of the total cost
Tier 5: Specialty	31% of the total cost	31% 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.	31% of the total cost
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

	PRESCRIPTION DRUGS Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006
Deductible	$300 Applies to: Tier 3, Tier 4, Tier 5 You pay 100% of covered prescription drug costs until the deductible is met. After you meet your deductible, you will pay a consistent 25% of the cost of your covered drugs until you reach the out-of-pocket maximum.

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	PRESCRIPTION DRUGS Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006				
Maximum out-of-pocket (MOOP)	$2,100 Out-of-Pocket Maximum**:** Your total out-of-pocket costs for prescription drugs will be capped at $2,100 per year. Once you reach this cap, you will not have to pay any more out-of-pocket costs for your prescription drugs for the remainder of the year.				
Pharmacy Type	**Preferred Retail 30-day supply**	**Non-Preferred Retail 30-day supply**	**Preferred Retail 90-day supply**	**Non-Preferred Retail 90-day supply**	**Preferred Mail Order 30-day supply**
Tier 1: Preferred Generic	$0 copay	$5 copay	$0 copay	$15 copay	$0 copay
Tier 2: Generic	$5 copay	$10 copay	$15 copay	$30 copay	$0 copay
Tier 3: Preferred Brand	20% of the total cost	20% of the total cost	20% of the total cost	20% of the total cost	20% of the total cost
Tier 4: Non-Preferred Drug	35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost

	PRESCRIPTION DRUGS Clear Spring Health Balance+ Diabetes & Heart (HMO C-SNP) H5454-006				
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 total cost
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

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.

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.

The **Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. See the Evidence of Coverage for more details about the program and how to participate in the program.