



Clear Spring
Health

Enabling a life well lived™

2025 SUMMARY OF BENEFITS

COLORADO

2025 Summary of Benefits

Clear Spring Health Essential (PPO) H8014-001

SUMMARY OF BENEFITS

2025



This is a summary of health and drug services covered by Clear Spring Health Essential (PPO) from January 1, 2025 – December 31, 2025.

Clear Spring Health has a contract with Medicare to offer HMO, PPO, and PDP 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 2025 “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 dial 711. The Evidence of Coverage will be available on our website by no later than October 15, 2024.

To join Clear Spring Health Essential (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare B, and live in our service area. Our service area includes the following counties in Colorado:

For plan **H8014-001**: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld.

If you use the 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](https://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 (!) indicates 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, 2026.

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK		OUT-OF-NETWORK
Monthly Plan Premium	<p>\$0</p> <p>You must continue to pay your Medicare Part B premium.</p>		
Deductible (Part C - Medical)	<p>\$0</p>		
Maximum Out-of-Pocket	<p>\$5,500 for in network benefits. \$8,950 for in and out of network.</p>		
Inpatient Hospital Coverage - Acute (!)	<p>\$300 copay per day for days 1-5; \$0 copay per day for days 6-90</p>	<p>45% of the total cost per day for days 1-5; 0% of the total cost per day for days 6-90</p>	
Inpatient Hospital Coverage – Psychiatric (!)	<p>\$275 copay per day for days 1-6; \$0 copay per day for days 7-90</p>	<p>45% of the total cost per day for days 1-6; 45% of the total cost per day for days 7-90</p>	
Outpatient Hospital Coverage (!)	<p>\$45 copayment for some skin tag removals performed at a dermatologist's office. \$340 copayment for all other services.</p> <p>Prior authorization required for Medicare-covered Observation Services after 24 hours.</p>	<p>45% of the total cost</p>	

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
Ambulatory Surgical Center (ASC) Services (!)	\$45 copayment for some skin tag removals performed at a dermatologist's office. \$290 copayment for all other services.	45% of the total cost
Doctor Visits (Primary Care Providers and Specialists) (!)	<p>Primary Care: \$0 copay</p> <p>Specialist: \$0 copay for Endocrinologist Specialist. \$20 copay for all other Specialists.</p> <p>Some procedures done in the specialists' office may require prior authorization.</p>	<p>Primary Care: 45% of the total cost</p> <p>Specialist: 45% of the total cost</p> <p>Some procedures done in the specialists' office may require prior authorization.</p>
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	\$0 copay for preventive care.	45% of the total cost for preventive care.
Emergency Care	<p>\$90 copay</p> <p>ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	
Urgently Needed Services	<p>\$30 copay</p> <p>Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
Diagnostic Services/Labs/Imaging (!) Diagnostic tests and procedures Lab Services Diagnostic radiology Outpatient x-rays	Diagnostic Tests and procedures: \$0 copay Lab Services: \$0 copay Diagnostic Radiology: \$20 copayment for some diagnostic ultrasound and diagnostic bone density imaging. \$175 copayment for all other Diagnostic Radiological Services (e.g., CT, MRI). X-rays: \$20 copay.	Diagnostic Tests and procedures: 45% of the total cost Lab Services: 45% of the total cost Diagnostic Radiology: 45% of the total cost. X-Rays: 45% of the total cost.
Hearing Services Routine Hearing Exam	Medicare Covered Hearing Exam: \$0 copay	Medicare Covered Hearing Exam: 45% of the total cost
Hearing Aids	Routine Hearing Exam: 1 exam every year. \$0 copay. Hearing aids: \$500 maximum plan coverage amount every year (per ear) for in- and out-of-network prescription hearing aids. Hearing aids must be purchased through NationsHearing to access the benefit. Fitting and Evaluation: \$0 copay	Routine Hearing Exam: 1 exam every year. 45% of the total cost. Hearing aids: 45% of the total cost Fitting and Evaluation: 45% of the total cost

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
Dental Services	Medicare Covered Dental Services: \$30 copay	Medicare Covered Dental Services: 45% of the total cost
	<p>Non-Medicare Covered Dental Services:</p> <p>Preventive Services: \$0 copay Comprehensive Services: \$0 copay</p> <p>\$1,500 maximum plan coverage amount every year for in- and out- of-network non-Medicare-covered comprehensive dental services.</p> <p>Refer to the Evidence of Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered.</p> <p>Dental services provided and administered by our partner, DentaQuest.</p>	<p>All out-of-network dental services are 45% copay.</p> <p>Refer to the Evidence of Coverage, Chapter 4, Medical Benefit Chart, for detailed information on what dental services and procedures are covered.</p>

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
Vision Services	Medicare Covered Eye Exam Services: \$0 copay	Medicare Covered Eye Exam Services: 45% of the total cost
	<p>Routine Eye Exam: 1 exam every year</p> <p>\$0 copay for routine eye exam.</p> <p>\$150 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear.</p> <p>Vision services provided and administered by our partner, EyeQuest.</p>	<p>Routine Eye Exam: 1 exam every year</p> <p>45% of the total cost for routine eye exam.</p> <p>45% of the total cost for Medicare-covered eyewear.</p> <p>\$150 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear.</p>
Mental Health Services	<p>Mental Health (Individual sessions): \$40 copay</p> <p>Mental Health (Group sessions): \$40 copay</p>	<p>Mental Health (Individual sessions): 45% of the total cost</p> <p>Mental Health (Group sessions): 45% of the total cost</p>
Skilled Nursing Facility (!)	\$0 copay per day for days 1-20; \$178 copay per day for days 21-100	45% of the total cost per day for days 1-20; 45% of the total cost per day for days 21-100
Physical & Speech Therapy (!)	\$40 copay	45% of the total cost
Ambulance (!)	<p>Ground: \$270 copay</p> <p>Prior authorization is needed for non-emergency ambulance rides.</p> <p>Air: \$270 copay</p>	<p>Ground: \$275 copay</p> <p>Prior authorization is needed for non-emergency ambulance rides.</p> <p>Air: \$275 copay</p>

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
Transportation	Not Covered	
Medicare Part B Drugs (!)	<p>0% to 20% of the total cost.</p> <p>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</p>	<p>45% of the total cost.</p>
Over-the-Counter Benefit	<p>\$60 maximum plan coverage amount every month for OTC items. Unused portion does not carry over to the next period.</p>	

	CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001 IN-NETWORK	OUT-OF-NETWORK
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. Access to over 15,000 locations nationwide. Members get access to SilverSneakers LIVE online classes, On-Demand videos, and thousands of fitness locations and classes.	

PRESCRIPTION DRUGS CLEAR SPRING HEALTH ESSENTIAL (PPO) H8014-001					
Deductible	\$0				
Maximum out of Pocket	\$2,000 OUT-OF-POCKET MAXIMUM Your total out-of-pocket costs for prescription drugs will be capped at \$2,000 per year. You will pay the below cost-shares until you reach the maximum out-of-pocket. 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	\$9 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2: Generic	\$0 copay	\$14 copay	\$0 copay	\$42 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

[illegible]

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.

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.