Clear Spring Health

Summary of Benefits – Clear Spring Health Essential PPO Virginia

January 1, 2020 - December 31, 2020

Clear Spring Health is the health plan that cares. We cover everything Original Medicare covers and provide you with additional benefits to optimize your health care needs. Our goal is to promote healthy outcomes by providing robust primary and preventative care, access to health and wellness services, and a unique approach to health care delivery. As a member of our plan, your health care matters. We have enhanced some of our 2020 plan benefits based on member feedback.

This booklet gives you a summary of what we cover and what you as a member can expect to pay. Please keep in mind, however, it doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us or refer to your "Evidence of Coverage Booklet." You can also find a copy on our website at www.clearspringhealthcare.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Clear Spring Health Essential PPO).
- In an PPO plan, except in an emergency situation, if you use providers that are not in our network, your costs may be higher, deductibles and coinsurances may apply.

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.

Sections in this booklet

- Things to Know About Clear Spring Health Essential PPO
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

Clear Spring Health is a PPO plan sponsor with a Medicare contract. Enrollment in a Clear Spring Health plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium.

Things to Know About Clear Spring Health Essential PPO

Hours of Operation	• From October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. • From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.
Clear Spring Health Essential PPO Phone numbers and website	• If you are a member of this plan, call toll-free 1-877-384-1241 • TTY/TDD users can call 711 • If you are not a member of this plan, call toll-free 1-877-384-1241 • Our website: www.clearspringhealthcare.com
Who can join?	To join 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. Our service area includes the following counties in Virginia: Chesterfield, Colonial Heights, Hanover, Henrico, Hopewell City, Petersburg City, Richmond City.
Which doctors, hospitals, and pharmacies can I use?	Clear Spring Health Essential PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, your costs may be higher, deductibles and coinsurances may apply. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider directory and pharmacy directory on our website (www.clearspringhealthcare.com). Or, call us and we will send you a copy of the provider and pharmacy directories.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers - and more. • **For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. • **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

	• You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, (www.clearspringhealthcare.com) • Or, call us and we will send you a copy of the formulary
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?	$0.00 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$0.00
Is there any limit on how much I will pay for my covered services? **What is my maximum out-of-pocket responsibility?**	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: $5,000 for services you receive from in-network providers. The combined yearly limit for covered in-network and out-of-network cost is $10,000. 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Benefit	***Original Medicare***	***Clear Spring Health Essential PPO***
Inpatient Hospital Care (1)	In 2019, the amounts for each benefit period are: • You pay a $1,364 deductible and no coinsurance for days 1–60 of each benefit period.	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than

Inpatient Hospital Care (1) cotninued	• You pay $341 copay per day for days 61–90 of each benefit period. • You pay $682 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime). • You pay all costs for each day after you use all the lifetime reserve days. These amounts may change for 2020.	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 Network Inpatient Hospital Care: • You pay a $304 copay per day for days 1 through 6. • $0 per day for days 7 through 90. Out-of-Network Inpatient Hospital Care: • You pay 45% coinsurance for days 1 through 90. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Outpatient Hospital Care (1, 3)	You pay 20% coinsurance per visit for the doctor's services. You pay a 20% Specified coinsurance for outpatient hospital facility services. The coinsurance cannot exceed the Part A inpatient hospital deductible. You pay a 20% coinsurance for ambulatory surgical center facility services.	In-Network Outpatient Hospital Care • Outpatient hospital: You pay a $45 minimum to a $300 maximum copay. • Ambulatory surgical center: You pay a $45 minimum to a $260 maximum copay. Out-of-Network Outpatient Hospital Care • You pay 45% coinsurance of covered expenses.
Doctor's Office Visits (3)	If the Part B deductible ($185 in 2019) applies, you must pay all costs (up to the Medicare-approved amount) until you meet the yearly Part B deductible. You pay 20% of the Medicare-approved amount (except for certain preventive services for which you may pay nothing).	In-Network Doctor's Office Visits • You pay a $10 copay for a Primary care physician visit. • You pay a $45 copay for the following specialty services: Ophthalmology, Gastrointestinal (GI) and professional radiology specialties. • You pay a $45 copay for all other Specialist visit.

Doctor's Office Visits (3) continued		• **You pay nothing** for Certain telehealth services, including: Primary Care Physician Services. Out-of-Network Doctor's Office Visits • You pay 45% coinsurance of covered expenses.
Preventative Care	Medicare-covered preventive services covered at zero cost sharing and includes: • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit • Abdominal aortic aneurysm screening 43 Alcohol misuse screening and counseling • Bone mass measurement (bone density) • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screenings • Diabetes self-management training • Flu shots • Glaucoma tests • Hepatitis B shots • Hepatitis C screening test • HIV screening • Lung cancer screening • Medical nutrition therapy services • Obesity screening and counseling • Pneumococcal shot • Prostate cancer screenings • Sexually transmitted infections screening and counseling	In-Network Preventive Services You are covered for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply. Plan covers a physical exam annually. Out-of-Network Preventive Services You pay 45% coinsurance of covered expenses.

Preventative Care continued	• Smoking and tobacco use cessation counseling	
Emergency Care (3)	You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a 20% coinsurance for facility services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. Not covered outside the U.S. except under limited circumstances.	• You pay a $90 copay for Emergency care. Worldwide Emergency/Urgent Coverage is included. You pay a $90 copay up to a $50,000 maximum benefit.
Urgently Needed Services (3)	You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. In a hospital outpatient setting, you also pay the hospital a copayment.	• You pay a $40 copay for Urgent care services.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (*Costs for these services may vary based on place of services)* **(1,3)**	You pay 20% of the Medicare-approved amount for Medicare covered X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. If you get the test at a hospital as an outpatient, you also pay the hospital coinsurance of 20% but in most cases, this amount can't be more than the Part A hospital stay deductible. Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests.	In-Network Services • Diagnostic radiology services (such as MRIs, CT scans): You pay a $20 minimum to a $175 maximum copay. • Diagnostic tests and procedures: $25 copay. • Outpatient x-rays: $45 copay**.** • Lab services: $25 copay. • Medicare Covered Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% coinsurance.

Diagnostic Tests, Lab and Radiology Services, and X-Rays (*Costs for these services may vary based on place of services)* **(1,3) Continued**	You generally pay nothing for these services.	Out-of-Network Services • You pay 45% of covered expenses
Hearing Services (3)	You pay 20% coinsurance for a Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. Routine hearing exams and hearing aids are not covered by Original Medicare.	In-Network Benefits: • A Medicare-covered hearing exam to diagnose and treat hearing and balance issues: You pay a $45 copay. • Routine hearing exams: You pay a $0 copay**.** • Hearing aid fitting/ evaluations: You pay a $0 copay**.** One (1) hearing aid is covered with a $400 copay every three (3) years. You must see a NationsHearing provider to use this benefit Out-of-Network Benefits: • Medicare covered hearing exams are subject to 45% coinsurance. There is no out-of-network option for supplemental hearing services.
Dental Services	Medicare does not cover most dental services (this includes services in connection with preventative care, treatment, filling, removal, or replacement of teeth).	In-Network Benefits: Preventive dental services: • Cleaning: $0 copay. • Dental x-ray(s): $0 copay. • Fluoride treatment $0 copay. • Oral exam: $0 copay. Our plan pays up to $1000 every year for most preventive dental services (in-network only) Comprehensive dental services: • Restorative Services: $0 copay

Dental Services continued		• Root canals: $0 copay**.** • Endodontics: $0 copay. • Periodontics: $0 copay. • Extractions: $0 copay • Dentures or fixed prosthetics: $0 copay**.** Medicare Comprehensive Dental Services are subject to a $45 copayment. Our plan pays up to $1000 every year for most comprehensive dental services (in-network only). Out of Network Benefits: Non-Medicare Covered Preventive and Comprehensive Dental Benefits are covered with $0 copayment and are limited to $1,000 every year. Medicare covered Comprehensive Dental Benefits are subject to 45% coinsurance.
Vision Services (1,3)	You pay 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.	In-Network Benefits: You pay $45 copay for an exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). Non-Medicare covered eyewear is not covered. Out-of-Network Benefits: Medicare Covered Eye Exams and Eyewear are subject to 45% coinsurance. Non-Medicare covered Eye Exams are covered.

Inpatient Mental Health Care (1,2)	In 2019, the amounts for each benefit period are: • You pay a $1,364 deductible and no coinsurance for days 1–60 of each benefit period. • You pay $341 per day for days 61–90 of each benefit period. • You pay $682 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime). • You pay all costs for each day after you use all the lifetime reserve days. Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime. These amounts may change for 2020.	**Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.** **In-Network Benefits:** • You pay a $330 copay per day for days 1 through 5. • You pay a $0 copay per day for days 6 through 90. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. You pay all costs for each day after you use all the lifetime reserve days. Out-of-Network Benefits: • You pay 45% coinsurance for days 1 through 90.
Outpatient Mental Health Care (1,2,3)	Generally, you pay 20% of the Medicare-approved amount: • Visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions. • Outpatient treatment of your condition (like counseling or psychotherapy). • Partial hospitalization program is a structured program of active outpatient psychiatric treatment that is more intense than the care received in our doctor's or therapist's office and is an alternative to inpatient hospitalization.	In-Network Benefits: • Outpatient individual therapy visit: You pay a $40 copay. • Outpatient group therapy visit: You pay a $40 copay. • Outpatient partial hospitalization visit: You pay a $55 copay. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Outpatient Substance Abuse (1,3)	You pay 20% coinsurance of the Medicare-approved amount.	In-Network Benefits:

Outpatient Substance Abuse (1,3) continued		Outpatient individual therapy visit: You pay a $40 copay. Outpatient group therapy visit: You pay a $40 copay. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Skilled Nursing Facility (SNF) (1,3)	In 2019, you pay: Medicare requires a three (3) day inpatient hospital stay prior a SNF admission. • $0 for the first 20 days of each benefit period. • $170.50 per day for days 21–100 of each benefit period. • All costs for each day after day 100 in a benefit period. These amounts may change for 2020.	In-Network Benefits: Our plan covers up to 100 days in a SNF. A three (3) day inpatient hospital stay is required prior to a SNF admission. • You pay a $0 copay per day for days 1 through 20. • You pay a $178 copay per day for days 21 through 100. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses for days 1 to 100.
Outpatient Rehabilitation (1,3)	Cardiac (heart) rehab services: You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. Occupational therapy: You pay 20% of the Medicare-approved amount. Physical therapy and speech therapy: You pay 20% of the Medicare-approved amount.	In-Network Benefits: • Cardiac (heart) rehab services: You pay a $30 minimum to a $45 maximum copay per service. • Occupational therapy visits: You pay a $40 copay per visit. • Physical therapy and speech and language therapy visits: You pay a $40 copay per visit. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Ambulance (3)	You pay 20% of the Medicare-approved amount.	• For each covered one-way trip on ground: You pay a $300 copay.

Ambulance (3) continued		• Covered air transportation: You pay a $300 copay.
Transportation (non-emergency)	Not Covered	Non-emergency transportation is not covered by this plan.
Foot Care *(podiatry services)* **(1,3)**	You pay 20% of the Medicare-approved amount. Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	In-Network Benefits: You pay a $45 copay for Medicare covered Podiatry care. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses. Routine Podiatry services are not covered.
Diabetes Supplies and Services (1,3)	You pay 20% coinsurance for diabetes supplies. You pay 20% coinsurance for diabetes self-management training. You pay 20% coinsurance for diabetic therapeutic shoes or inserts.	In-Network Benefits: Diabetes monitoring supplies: You pay a $0 copay. Diabetes self-management training: You pay a $0 copay. Therapeutic shoes or inserts: You pay a $0 copay. Authorization is required after 1 pair of diabetic shoes and 3 inserts. Out-of-Network Benefits: You pay 20% coinsurance of covered expenses. Plan covers specified manufactures for diabetes monitoring supplies.
Durable Medical Equipment (wheelchairs, oxygen, etc.) **(1, 3)**	You pay 20% of the Medicare-approved amount.	Durable Medical Equipment (DME): You pay 20% of the total cost. If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.

Wellness Programs		
Health Club Membership SilverSneakers® Fitness	Not covered	You pay $0 copay to belong to a participating health club while you are a member of our plan. You can find a list of participating clubs on our website at www.clearspringhealthcare.com or call Member Services 877-384-1241 (TTY): 711.
Over-the-Counter Items	Not covered	Not covered.

Part B Drugs (1)	For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount, and the Part B deductible may apply. You pay 20% of the Medicare-approved amount for other covered drugs, and the Part B may deductible apply.	In-Network Benefits: • For Part B drugs such as chemotherapy drugs: 20% of the total cost. • Other Part B drugs: 20% of the total cost. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.

Prescription Drug Benefits		
Initial Coverage		
Deductible	Center for Medicare and Medicaid Services defined Standard Benefit Plan deductible for 2020 is $435.	$0 Deductible
Initial Coverage	In Original Medicare, if you don't already have creditable prescription drug coverage (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, by joining a Medicare Advantage Plan.	You pay the following until your total yearly drug costs reach $4,020. 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 for a one month supply only.

Initial Coverage continued		Medications administered as part of home infusion therapy require 20% coinsurance. You may get drugs from an out-of-net-work retail pharmacy at the same cost as an in-network retail pharmacy for a one month supply only. For retail cost-sharing see table 1. For mail order cost-sharing see table 2.

Table 1

Standard retail cost-sharing (in-network)	**One-Month supply**	**Three-Month supply**
Tier 1 Preferred Generic	$2 copay	$6 copay
Tier 2 Generic	$5 copay	$15 copay
Tier 3 Preferred Brand	$42 copay	$126 copay
Tier 4 Non-Preferred Brand	$100 copay	$300 copay
Tier 5 Specialty Tier	33% of the cost	N/C

Table 2

Standard Mail Order Cost-Sharing	**One-month supply**	**Three-month supply**
Cost-Sharing Tier 1 Preferred Generic	$2 copay	$0 copay
Cost-Sharing Tier 2 Generic	$5 copay	$10 copay
Cost-Sharing Tier 3 Preferred Brand	$42 copay	$121 copay
Cost-Sharing Tier 4 Non-Preferred Brand	$100 copay	$300 copay
Cost-Sharing Tier 5 Specialty Tier	33% of the cost	N/C

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 $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $6,350, 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 $6,350**,** you pay the greater of: • 5% of the cost, or • $3.60 copay for generic (including brand drugs treated as generic) and $8.95 for all other drugs.

Other Care and Services		
Chiropractic Care (1,3)	Medicare covers manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. You pay 20% of the Medicare-approved amount.	In-Network Benefits: Manipulation of the spine to correct a subluxation (when one (1) or more of the bones of your spine move out of position): You pay a $20 copay. No authorization required for the first 4 visits. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Home Health Care (1)	You pay $0 copay for covered home health care services.	In-Network Benefits: You pay a $0 copay Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare certified hospice.	You must get care from a Medicare certified hospice. You must consult with your plan before you select hospice.
Prosthetic Devices *(braces, artificial limbs, etc.)* **(1,3)**	For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount.	In-Network Benefits: Prosthetic devices: You pay 20% of the total cost. Related medical supplies: You pay 20% of the total cost.

Prosthetic Devices *(braces, artificial limbs, etc.)* **(1,3)** *continued*		Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.
Renal Dialysis (2,3)	You pay 20% of the Medicare-approved amount.	In-Network Benefits: You pay 20% of the total cost. Out-of-Network Benefits: You pay 45% coinsurance of covered expenses.

(1) This service may require prior authorization
(2) This service may require a referral from your doctor
(3) Under Original Medicare the Part B deductible applies for this service

Clear Spring Health

Notice of Non-Discrimination

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

Clear Spring Health:

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 Clear Spring Health. If you believe that Clear Spring Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Clear Spring Health, Attn: Grievance Department, ***P.O. Box 4107, Scranton, PA 18505***, (877) 384-1241, TTY number—711, ***fax # (855) 382-6674***. We are available 8:00 am to 8:00 pm Monday – Friday from April 1 – September 30 and 8:00 am to 8:00 pm Monday – Sunday from October 1 – March 31. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Clear Spring Health is available to help you.

You can 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. 20201 Phone: 1-800-368-1019,
800-537-7697 (TDD)

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

Clear Spring Health

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 877-384-1241 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-384-1241 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-384-1241 (TTY: 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 877-384-1241 (TTY:711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-384-1241 (TTY: 711) 번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-384-1241 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث العربية، خدمات المساعدة اللغوية، مجانا، تتوفر لك. اتصل بالرقم 1241-384-877 (تي: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-384-1241 (TTY:711).

Gujarati: સચના: જો તમ ગજરાતી બોલતા હો, તો નિ:શલક ભાષા સહાય સવાઓ તમારા માટ ઉપલબધ છ. ફોન કરો 877-384-1241 (TTY: 711).

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (TTY: 711). 877-384-1241

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-384-1241 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-384-1241 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।877-384-1241 (TTY: <TTY>) पर कॉल करें।

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877-384-1241 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 877-384-1241 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-384-1241 (TTY: 711).