2015
Summary of Benefits

Humana Gold Plus®
H1036-138 (HMO)
Greensboro/Winston Salem
Greensboro / Winston-Salem Metro Area
2015
Summary of Benefits

Humana Gold Plus®
H1036-138 (HMO)
Greensboro/Winston Salem
Greensboro / Winston-Salem Metro Area
SECTION 1

Summary of Benefits
January 1, 2015 - December 31, 2015

This booklet gives you a summary of what we cover and what you pay. 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 and ask for the “Evidence of Coverage.”

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 Humana Gold Plus H1036-138 (HMO)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Humana Gold Plus H1036-138 (HMO) covers and what you pay.
• 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 Humana Gold Plus H1036-138 (HMO)
• Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
• Covered Medical and Hospital Benefits
• Prescription Drug Benefits

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 1-800-457-4708. Es posible que este documento esté disponible en otros idiomas aparte de inglés. Para obtener información adicional, llame al Servicio al Cliente al número de teléfono que se indica a continuación.

Things to Know About Humana Gold Plus H1036-138 (HMO)

Hours of Operation

• From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.
• From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

Humana Gold Plus H1036-138 (HMO) Phone Numbers and Website

• If you are a member of this plan, call toll-free 1-800-457-4708.
• If you are not a member of this plan, call toll-free 1-800-833-2364.
• Our website: http://www.humana-medicare.com
Who can join?

To join Humana Gold Plus H1036-138 (HMO), 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 North Carolina: Alamance, Alleghany, Ashe, Caswell, Davidson, Davie, Forsyth, Guilford, Person, Randolph, Rockingham, Stokes, Wilkes, and Yadkin.

Which doctors, hospitals, and pharmacies can I use?

Humana Gold Plus H1036-138 (HMO) 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. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider directory at our website (http://www.humana.com/members/tools). You can see our plan's pharmacy directory at our website (http://www.humana.com/Medicare/medicare_prescription_drugs/). 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.

- Our plan members get all of the benefits covered by Original Medicare. 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, http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/.
- 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 after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.
Summary of Benefits
January 1, 2015 - December 31, 2015

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

<table>
<thead>
<tr>
<th>How much is the monthly premium?</th>
<th>$0 per month. In addition, you must keep paying your Medicare Part B premium.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is the deductible?</td>
<td>$200 per year for Part D prescription drugs.</td>
</tr>
<tr>
<td>Is there any limit on how much I will pay for my covered services?</td>
<td>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: • $4,900 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.</td>
</tr>
</tbody>
</table>

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.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

Covered Medical and Hospital Benefits

Note:
• Services with a ¹ may require prior authorization.
• Services with a ² may require a referral from your doctor.

OUTPATIENT CARE AND SERVICES
Acupuncture and Other Alternative Therapies
Not covered

Ambulance¹ $250 copay

Chiropractic Care¹²
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay

Dental Services
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $45 copay
Preventive dental services:
Cleaning (for up to 1 every year): You pay nothing
Dental x-ray(s) (for up to 1 every year): You pay nothing
Oral exam (for up to 1 every year): You pay nothing

For detailed benefit information please call the Customer Care number listed in the Things To Know About Your Plan section above.
### SECTION 2 (continued)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Supplies and Services</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Diabetes monitoring supplies: 0–20% of the cost, depending on the supply</td>
</tr>
<tr>
<td></td>
<td>Diabetes self-management training: You pay nothing</td>
</tr>
<tr>
<td></td>
<td>Therapeutic shoes or inserts: $10 copay</td>
</tr>
<tr>
<td><strong>Diagnostic Tests, Lab and Radiology Services, and X-Rays</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Diagnostic radiology services (such as MRIs, CT scans): $195–245 copay, depending on the service</td>
</tr>
<tr>
<td></td>
<td>Diagnostic tests and procedures: $0–95 copay, depending on the service</td>
</tr>
<tr>
<td></td>
<td>Lab services: $0–95 copay, depending on the service</td>
</tr>
<tr>
<td></td>
<td>Outpatient x-rays: $10–95 copay, depending on the service</td>
</tr>
<tr>
<td></td>
<td>Therapeutic radiology services (such as radiation treatment for cancer): $45 copay or 20% of the cost, depending on the service</td>
</tr>
<tr>
<td></td>
<td>If you receive Diagnostic radiology services (such as MRIs, CT scans) at the Primary Care Doctor’s or Specialist’s office you will also pay the office visit copay.</td>
</tr>
<tr>
<td><strong>Doctor’s Office Visits</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Primary care physician visit: $10 copay</td>
</tr>
<tr>
<td></td>
<td>Specialist visit: $10–45 copay, depending on the service</td>
</tr>
<tr>
<td></td>
<td>For coumadin services received at an in-network specialist’s office, you pay $10 copayment</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (wheelchairs, oxygen, etc.)</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>20% of the cost</td>
</tr>
<tr>
<td></td>
<td>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>$65 copay</td>
</tr>
<tr>
<td></td>
<td>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the &quot;Inpatient Hospital Care&quot; section of this booklet for other costs.</td>
</tr>
<tr>
<td><strong>Foot Care (podiatry services)</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $45 copay</td>
</tr>
<tr>
<td><strong>Hearing Services</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Exam to diagnose and treat hearing and balance issues: $45 copay</td>
</tr>
<tr>
<td><strong>Home Health Care</strong>&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>You pay nothing</td>
</tr>
</tbody>
</table>
### SECTION 2 (continued)

| Mental Health Care<sup>1,2</sup> | 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.  
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 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.  
  - **$245** copay per day for days 1 through 6  
  - **You pay nothing** per day for days 7 through 90  
Outpatient group therapy visit: **$40** copay  
Outpatient individual therapy visit: **$40** copay  
You pay:  
  - **$40** copayment at a hospital facility for partial hospitalization  
  - **$95** copayment at a hospital facility as an outpatient. |
| --- | --- |
| Outpatient Rehabilitation<sup>1,2</sup> | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **$10** copay  
Occupational therapy visit: **$10-$40** copay, depending on the service  
Physical therapy and speech and language therapy visit: **$10-$40** copay, depending on the service |
| Outpatient Substance Abuse<sup>1,2</sup> | Group therapy visit: **$95** copay  
Individual therapy visit: **$95** copay  
You pay:  
  - **$40** copayment at a hospital facility for partial hospitalization  
  - **$95** copayment at a hospital facility as an outpatient. |
| Outpatient Surgery<sup>1,2</sup> | Ambulatory surgical center: **$195** copay  
Outpatient hospital: **$10-$245** copay or **20%** of the cost, depending on the service |
| Over-the-Counter Items | Please visit our website to see our list of covered over-the-counter items.  
  - You are eligible to receive a **$40** monthly benefit toward the purchase of selected over-the-counter items when you use Humana's mail order service.  
  - For more information or to request an order form, please call Customer Care. |
| Prosthetic Devices (braces, artificial limbs, etc.)<sup>1</sup> | Prosthetic devices: **20%** of the cost  
Related medical supplies: **20%** of the cost |
| Renal Dialysis<sup>1,2</sup> | **20%** of the cost |
| Transportation<sup>1</sup> | **You pay nothing**  
  - 12 one-way non emergency trips per year for plan approved locations.  
  - This benefit is not to exceed 25 miles per trip. |
## Urgent Care

$10-45$ copay, depending on the service

For each Medicare-covered urgently needed care visit, you pay:
- $10 copayment at your primary care doctor’s office
- $45 copayment at a specialist’s office
- $45 copayment at an immediate care facility

## Vision Services

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-45$ copay, depending on the service

Routine eye exam (for up to 1 every year): **You pay nothing**

Contact lenses (for up to 1 every year): **You pay nothing**

Eyeglasses (frames and lenses) (for up to 1 every year): **You pay nothing**

Eyeglasses or contact lenses after cataract surgery: **You pay nothing**

Our plan pays up to $100 every year for contact lenses and eyeglasses (frames and lenses).

## Preventive Care

**You pay nothing**

Our plan covers many preventive services, including:
- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

## Hospice

**You pay nothing** for hospice care from a Medicare-certified hospice.

You may have to pay part of the cost for drugs and respite care.
SECTION 2 (continued)

INPATIENT CARE

Inpatient Hospital Care\(^1,2\)

Our plan covers an unlimited number of days for an inpatient hospital stay.

- **$245** copay per day for days 1 through 7
- **You pay nothing** per day for days 8 through 90
- **You pay nothing** per day for days 91 and beyond

Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet

Skilled Nursing Facility (SNF)\(^1,2\)

Our plan covers up to 100 days in a SNF.

- **$0** copay per day for days 1 through 20
- **$156** copay per day for days 21 through 100

Prescription Drug Benefits

How much do I pay?

For Part B drugs such as chemotherapy drugs\(^1\): **20%** of the cost

Other Part B drugs\(^1\): **20%** of the cost.

Deductible listed under Monthly Premium, Deductible, and Limits on How Much you Pay for Covered Services applies to: Tier V, Tier IV

Initial Coverage

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$2,960**. 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.

<table>
<thead>
<tr>
<th>Standard Retail Cost-Sharing</th>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$5 copay</td>
<td>$15 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$17 copay</td>
<td>$51 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45 copay</td>
<td>$135 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$95 copay</td>
<td>$285 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>28% of the cost</td>
<td>Not Offered</td>
<td></td>
</tr>
</tbody>
</table>
### Preferred Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$5 copay</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$17 copay</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45 copay</td>
<td>$125 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$95 copay</td>
<td>$275 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>28% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

### Standard Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$5 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$17 copay</td>
<td>$51 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45 copay</td>
<td>$135 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$95 copay</td>
<td>$285 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>28% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

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, but may pay more than you pay at an in-network pharmacy.

Days' Supply Available:

- One-month supply = up to 30 days*
- Two-month supply = 31-60 days
- Three-month supply = 61-90 days

*Long Term Care Pharmacy (one month supply = 31 days)
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 $2,960.

After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.

Standard Retail Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>Some</td>
<td>$5 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>Some</td>
<td>$17 copay</td>
<td>$51 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>Some</td>
<td>$45 copay</td>
<td>$135 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>Some</td>
<td>$95 copay</td>
<td>$285 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>Some</td>
<td>28% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>
### Preferred Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>Some</td>
<td>$5 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>Some</td>
<td>$17 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>Some</td>
<td>$45 copay</td>
<td>$125 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>Some</td>
<td>$95 copay</td>
<td>$275 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>Some</td>
<td>28% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

### Standard Mail Order Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>Some</td>
<td>$5 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>Some</td>
<td>$17 copay</td>
<td>$51 copay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>Some</td>
<td>$45 copay</td>
<td>$135 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>Some</td>
<td>$95 copay</td>
<td>$285 copay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>Some</td>
<td>28% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:
- 5% of the cost, or
- $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs
As a member you must select an in-network doctor to act as your primary care physician (PCP). Your selected in-network PCP can focus on your needs and coordinate your care with other in-network physicians. This helps keep your out-of-pocket costs low and medical expenses predictable.

Additional Supplemental Benefits covered by the plan:
SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes
Member Assistance Program - A program that includes telephonic counseling sessions and online resources
Personal Health Coaching - An interactive program including on-line and telephonic wellness coaching
HumanaFirst® - A 24 Hour Nurse Advice Hotline
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility
Smoking Cessation Program - A program may include web based or telephonic counseling/coaching and Nicotine Replacement Therapy
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 1-800-457-4708. 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 1-800-457-4708. 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。如果您需要此项翻译服务，请致电1-800-457-4708。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantones:** 您对我们健康或药物保险可能有疑问，为此我们提供免费的翻译服务。如需翻译服务，请致电1-800-457-4708。我们懂中文的人员将乐意为您提供帮助。这是一项免费服务。

**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 1-800-457-4708. Maaari kayong tutulungan 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 votre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-457-4708. 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 trình bảo hiểm sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-281-6918 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.


**Korean:** 당사는 의료 보험 또는 약물 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-457-4708 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.
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 1-800-457-4708. Un nostro incaricato che parla Italiano vi fornirà l’assistenza necessaria. È un servizio gratuito.

Português: 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 1-800-457-4708. 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 1-800-457-4708. 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 1-800-457-4708. Ta usługa jest bezpłatna.

Japanese: 当社の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。通訳をご用命になるには、1-800-457-4708 にお電話ください。日本語を話す人材が支援いたします。これは無料のサービスです。