Summary of Benefits
Medicare Advantage Plans

Florida
Miami-Dade County
H1032
01/01/15 - 12/31/15
WellCare Dividend (HMO-POS)
040

WellCare Health Plans
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 WellCare Dividend (HMO-POS)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what WellCare Dividend (HMO-POS) 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 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 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 WellCare Dividend (HMO-POS)
- 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 1-877-374-4056, TTY 1-877-247-6272.


Things to Know About WellCare Dividend (HMO-POS)

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.

WellCare Dividend (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-888-888-9355, TTY 1-877-247-6272.
Section I - Introduction to Summary of Benefits

- If you are not a member of this plan, call toll-free 1-877-817-5793, TTY 1-877-247-6272.
- Our website: www.wellcare.com/medicare

Who can join?
To join WellCare Dividend (HMO-POS), 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 county in Florida: Miami-Dade.

Which doctors, hospitals, and pharmacies can I use?
WellCare Dividend (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

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 and pharmacy directory at our website (www.wellcare.com/medicare).

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, www.wellcare.com/medicare.
- 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 your drug’s tier, what stage of the benefit you have reached, and may depend on where you fill your prescription. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.
If you have any questions about this plan’s benefits or costs, please contact WellCare for details.

## Section II - Summary of Benefits
For Contract H1032, Plan 040

<table>
<thead>
<tr>
<th>Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services</th>
<th>WellCare Dividend (HMO-POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How much is the monthly premium?</strong></td>
<td>$0 per month. In addition, you must keep paying your Medicare Part B premium. WellCare will reduce your Medicare Part B premium by up to $104.90.</td>
</tr>
<tr>
<td><strong>How much is the deductible?</strong></td>
<td>This plan does not have a deductible.</td>
</tr>
</tbody>
</table>
| **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:
  - $6,700 for services you receive from in-network providers.
  - $6,700 for services you receive from out-of-network providers.
  - $6,700 for services you receive from any provider.
Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit.
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. |
WellCare Dividend (HMO-POS)

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

WellCare (HMO) is a Medicare Advantage organization with a Medicare contract. Enrollment in WellCare (HMO) 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

<table>
<thead>
<tr>
<th><strong>Acupuncture and Other Alternative Therapies</strong></th>
<th>Not covered</th>
</tr>
</thead>
</table>
| **Ambulance**¹ | · In-network: $100 co-pay  
· Out-of-network: 45% of the cost |

| **Chiropractic Care**¹,² | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):  
· In-network: You pay nothing  
· Out-of-network: 45% of the cost  
Routine chiropractic visit:  
· In-network: You pay nothing. You are covered for up to 24 every year. |

| **Dental Services**¹² | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):  
· In-network: You pay nothing  
· Out-of-network: 45% of the cost  
Preventive dental services:  
· Cleaning:  
· In-network: You pay nothing. You are covered for up to 1 every six months.  
· Dental x-ray(s):  
· In-network: You pay nothing. You are covered for up to 1. |
<table>
<thead>
<tr>
<th>Outpatient Care and Services</th>
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</tr>
</thead>
</table>
| **Dental Services**<sup>1,2</sup> | • Fluoride treatment:  
• In-network: You pay nothing. You are covered for up to 1 every year.  
• Oral exam:  
• In-network: You pay nothing. You are covered for up to 1 every six months.  
Our plan pays up to $1,000 every year for most dental services from an in-network provider.  
You are covered and pay nothing for additional comprehensive dental services including: DIAGNOSTICS, ENDODONTICS, RESTORATIVE, PERIODONTICS, EXTRACTIONS, PROSTHODONTICS and OTHER ORAL SURGERY. Limitations apply. |
| **Diabetes Supplies and Services**<sup>1,2</sup> | Diabetes monitoring supplies:  
• In-network: You pay nothing  
• Out-of-network: 45% of the cost  
Diabetes self-management training:  
• In-network: You pay nothing  
• Out-of-network: 45% of the cost  
Therapeutic shoes or inserts:  
• In-network: 20% of the cost  
• Out-of-network: 45% of the cost  
Diabetic supplies and services are limited to specific manufacturers. |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**<sup>1,2</sup> | Diagnostic radiology services (such as MRIs, CT scans):  
• In-network: 20% of the cost  
• Out-of-network: 45% of the cost  
Diagnostic tests and procedures:  
• In-network: You pay nothing  
• Out-of-network: 45% of the cost |
<table>
<thead>
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<th>Outpatient Care and Services</th>
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</tr>
</thead>
</table>
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**<sup>1,2</sup> | Lab services:  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost  
Outpatient x-rays:  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost  
Therapeutic radiology services (such as radiation treatment for cancer):  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost |
| **Doctor's Office Visits**<sup>1,2</sup> | Primary care physician visit:  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost  
Specialist visit:  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost |
| **Durable Medical Equipment (wheelchairs, oxygen, etc.)**<sup>1</sup> |  
  - In-network: **20%** of the cost  
  - Out-of-network: **45%** of the cost |
| **Emergency Care** | **$65** co-pay  
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 "Inpatient Hospital Care" section of this booklet for other costs. |
| **Foot Care (podiatry services)**<sup>1,2</sup> | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:  
  - In-network: You pay nothing  
  - Out-of-network: **45%** of the cost |
### Outpatient Care and Services

#### Hearing Services¹²

Exam to diagnose and treat hearing and balance issues:
- **In-network:** You pay nothing
- **Out-of-network:** 45% of the cost

Routine hearing exam:
- **In-network:** You pay nothing. You are covered for up to 1 every year.

Hearing aid fitting/evaluation:
- **In-network:** You pay nothing. You are covered for up to 1 every year.

Hearing aid:
- **In-network:** You pay nothing

Our plan pays up to **$350** every year for hearing aids from an in-network provider.

Our plan pays for 1 hearing aid up to $350 every year.

#### Home Health Care¹²

- **In-network:** You pay nothing
- **Out-of-network:** 45% of the cost

#### Mental Health Care¹²

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.
- **In-network:**
  - You pay nothing per day for days 1 through 90
- **Out-of-network:**
<table>
<thead>
<tr>
<th>WellCare Dividend (HMO-POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care and Services</strong></td>
</tr>
</tbody>
</table>
| **Mental Health Care**
  - 45% of the cost per stay
  - Outpatient group therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost
  - Outpatient individual therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost |
| **Outpatient Rehabilitation**
  - Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost
  - Occupational therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost
  - Physical therapy and speech and language therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost |
| **Outpatient Substance Abuse**
  - Group therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost
  - Individual therapy visit:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost |
| **Outpatient Surgery**
  - Ambulatory surgical center:
    - In-network: You pay nothing
    - Out-of-network: 45% of the cost
  - Outpatient hospital: |
<table>
<thead>
<tr>
<th>Outpatient Care and Services</th>
<th>WellCare Dividend (HMO-POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery</strong> ¹²</td>
<td>• In-network: You pay nothing</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 45% of the cost</td>
</tr>
<tr>
<td><strong>Over-the-Counter Items</strong></td>
<td>Please visit our website to see our list of covered over-the-counter items.</td>
</tr>
<tr>
<td></td>
<td>Our plan will pay up to $7 every month for the purchase of covered over-the-counter items.</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong> ¹</td>
<td>Prosthetic devices:</td>
</tr>
<tr>
<td></td>
<td>• In-network: 20% of the cost</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 45% of the cost</td>
</tr>
<tr>
<td></td>
<td>Related medical supplies:</td>
</tr>
<tr>
<td></td>
<td>• In-network: 20% of the cost</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 45% of the cost</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong> ¹²</td>
<td>• In-network: 20% of the cost</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 45% of the cost</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>You pay nothing</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 urgent care. See the &quot;Inpatient Hospital Care&quot; section of this booklet for other costs.</td>
</tr>
<tr>
<td><strong>Vision Services</strong> ¹²</td>
<td>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</td>
</tr>
<tr>
<td></td>
<td>• In-network: You pay nothing</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 45% of the cost</td>
</tr>
<tr>
<td></td>
<td>Routine eye exam:</td>
</tr>
<tr>
<td></td>
<td>• In-network: You pay nothing. You are covered for up to 1 every year.</td>
</tr>
<tr>
<td>WellCare Dividend (HMO-POS)</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Care and Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Vision Services</strong>1,2</td>
<td></td>
</tr>
<tr>
<td>Contact lenses:</td>
<td></td>
</tr>
<tr>
<td>• In-network: You pay nothing. You are covered for up to 1 every year.</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses (frames and lenses):</td>
<td></td>
</tr>
<tr>
<td>• In-network: You pay nothing. You are covered for up to 1 every year.</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses frames:</td>
<td></td>
</tr>
<tr>
<td>• In-network: You pay nothing. You are covered for up to 1 every year.</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses lenses:</td>
<td></td>
</tr>
<tr>
<td>• In-network: You pay nothing. You are covered for up to 1 every year.</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses or contact lenses after cataract surgery:</td>
<td></td>
</tr>
<tr>
<td>• In-network: You pay nothing</td>
<td></td>
</tr>
<tr>
<td>• Out-of-network: 45% of the cost</td>
<td></td>
</tr>
<tr>
<td>Our plan pays up to $100 every year for eyewear from an in-network provider.</td>
<td></td>
</tr>
<tr>
<td>Our plan covers 1 pair of eyeglasses or contact lenses after cataract surgery each year.</td>
<td></td>
</tr>
</tbody>
</table>

| Preventive Care |
| • In-network: You pay nothing |
| • Out-of-network: 45% of the cost |
| 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 |
### Outpatient Care and Services

#### Preventive Care
- 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.

#### Inpatient Care

##### Inpatient Hospital Care

<table>
<thead>
<tr>
<th>In-network:</th>
<th>Out-of-network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay nothing per day for days 1 through 90</td>
<td>45% of the cost per stay</td>
</tr>
<tr>
<td>You pay nothing per day for days 91 and beyond</td>
<td></td>
</tr>
</tbody>
</table>

##### Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in a SNF.

- In-network:
  - You pay nothing per day for days 1 through 20
  - $156.50 co-pay per day for days 21 through 100

For inpatient mental health care, see the "Mental Health Care" section of this booklet.
## WellCare Dividend (HMO-POS)

### Inpatient Care

**Skilled Nursing Facility (SNF)**
- Out-of-network: 45% of the cost per stay

### Prescription Drug Benefits

#### How much do I pay?

For Part B drugs such as chemotherapy drugs:
- In-network: 20% of the cost
- Out-of-network: 45% of the cost

Other Part B drugs:
- In-network: 20% of the cost
- Out-of-network: 45% of the cost

#### Initial Coverage

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.

#### Preferred Retail 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>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$10 co-pay</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$25 co-pay</td>
<td>$75 co-pay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$49 co-pay</td>
<td>$147 co-pay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% of the cost</td>
<td>Not Offered</td>
</tr>
<tr>
<td>Tier</td>
<td>One-month supply</td>
<td>Three-month supply</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$16 co-pay</td>
<td>$48 co-pay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$35 co-pay</td>
<td>$105 co-pay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$64 co-pay</td>
<td>$192 co-pay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

**Preferred Mail Order Cost-Sharing**

<table>
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<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>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Non-Preferred Generic)</td>
<td>$10 co-pay</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$25 co-pay</td>
<td>$62.50 co-pay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$49 co-pay</td>
<td>$122.50 co-pay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% 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>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
Prescription Drug Benefits

WellCare Dividend (HMO-POS)

### Initial Coverage

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<tr>
<th>Tier</th>
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<td>$105 co-pay</td>
</tr>
<tr>
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<td>$64 co-pay</td>
<td>$192 co-pay</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>

If you reside in a long-term care facility, you pay the Standard Retail Cost-Sharing.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

### 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.

### 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** co-pay for generic (including brand drugs treated as generic) and a **$6.60** co-payment for all other drugs.
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 1-877-374-4056. 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 1-877-374-4056. 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 1-877-374-4056。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 1-877-374-4056。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 1-877-374-4056. 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 1 877-374-4056. 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 quý vị cần thông dịch viên xin gọi 1-877-374-4056 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해드리는 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-374-4056 번으로 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 1-877-374-4056. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: نحن نقدم خدمات الترجمة الفورية المجانية للاجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا للحصول على ترجمة فوري، ليس عليك سوى الاتصال بنا على 4056-374-1877. سيقوم شخص ما بمساعدتك. هذه خدمة مجانية تحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-374-4056 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 1-877-374-4056. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Disponemos 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 1-877-374-4056. 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 ouswa dwôg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-374-4056. 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 1-877-374-4056. 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。通訳をご用命になるには、1-877-374-4056 にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。