HNE Medicare Premium (HMO) offered by HNE Medicare Advantage

Annual Notice of Changes for 2016

You are currently enrolled as a member of HNE Medicare Freedom (HMO-POS). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

Additional Resources

- Please contact our Member Services number at 1.413.787.0010 or toll free at 1.877.443.3314 (TTY only, call 1.800.439.2370). We are available for phone calls from 8:00 a.m. to 8:00 p.m., Monday through Friday. Calls to these numbers are free. (October 1 through February 14: 8:00 a.m. to 8:00 p.m., seven days a week.)
- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- We must provide information in a way that works for you (in large print, or other alternate formats, etc.). To get information from us in a way that works for you, please call Member Services (phone numbers are in Section 8.1 of this booklet).

About HNE Medicare Premium (HMO)

- HNE Medicare Advantage is an HMO plan with a Medicare contract. Enrollment in HNE Medicare Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Health New England (HNE) Medicare Advantage. When it says "plan" or "our plan," it means HNE Medicare Premium (HMO).

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Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

- **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.

- **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 2.3 for information about our Provider Directory.

- **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?

- **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with HNE Medicare Premium (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2016. Look in Section 5 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for HNE Medicare Premium (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$210	$164
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,400 in-network Not applicable out-of-network	$3,400 in-network Not applicable out-of-network

Cost	2015 (this year)		2016 (next year)
	In-Network	Out-of-Network	In-Network
Doctor office visits	Primary care visits: $15 per visit Specialist visits: $20 per visit	Primary care visits: $55 per visit Specialist visits: $55 per visit	Primary care visits: $15 per visit Specialist visits: $20 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$300 copay per admission. There is a $900 out-of-pocket limit every year.	$300 Per Day (Days 1-5). There is no out-of-pocket copay maximum for out-of-network.	$300 Per Day (Days 1-5) copay per admission. There is a $900 out-of-pocket limit every year.
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0		Deductible: $0
	Copays during the Initial Coverage Stage: • Drug Tier 1: $10 • Drug Tier 2: $45 • Drug Tier 3: $90 • Drug Tier 4: 33%		Copays during the Initial Coverage Stage: • Drug Tier 1: $10 • Drug Tier 2: $45 • Drug Tier 3: $90 • Drug Tier 4: 33%

Annual Notice of Changes for 2016
Table of Contents

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled HNE Medicare Premium (HMO) in 2016

On January 1, 2016, Health New England (HNE) Medicare Advantage will be combining HNE Medicare Freedom (HMO-POS) with one of our plans, HNE Medicare Premium (HMO).

If you nothing to change your Medicare coverage by December 7, 2015, we will automatically enroll you in our HNE Medicare Premium (HMO). This means starting January 1, 2016, you will be getting your medical and prescription drug coverage through HNE Medicare Premium (HMO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in HNE Medicare Freedom (HMO-POS) and the benefits you will have on January 1, 2016 as a member of HNE Medicare Premium (HMO).

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$210	$164

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2015 (this year)	2016 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year.

An updated Provider Directory is located on our website at www.hne.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2016 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.hne.com/medicare.You may also call Member Services for updated provider information or to ask us to email you a Pharmacy Directory. **Please review the 2016 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2016 Evidence of Coverage.*

Cost	2015 (this year)		2016 (next year)
	In-Network	Out-of-Network	
Ambulance Services	You pay: $100 copay for Medicare covered ambulance benefits per trip.	You pay: $100 copay for Medicare covered ambulance benefits per trip.	You pay: $150 copay for Medicare covered ambulance benefits per trip.
Inpatient Prosthetics and Orthotics	You pay: 10% coinsurance for Medicare covered items.	You pay: 20% coinsurance for Medicare covered items.	You pay: 15% coinsurance for Medicare covered items.
Outpatient DME	You pay: 10% coinsurance for Medicare covered items.	You pay: 20% coinsurance for Medicare covered items.	You pay: 15% coinsurance for Medicare covered items.

Cost	2015 (this year)		2016 (next year)
	In-Network	Out-of-Network	
Outpatient Emergency Department Visit	$65 copay for Medicare covered visits.	$65 copay for Medicare covered visits.	You pay: $75 copay for Medicare covered visits.
Outpatient X-rays and Other Radiology Services	You pay: $0 copay for Medicare covered X-rays. $100 copay for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.	You pay: 10% coinsurance for Medicare covered X-rays. 20% coinsurance for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.	You pay: $10 copay for Medicare covered X-rays. $100 copay for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.
Urgently Needed Services	You pay: $20 copay for Medicare covered urgently needed services.	You pay: $20 copay for Medicare covered urgently needed services.	You pay: $50 copay for Medicare covered urgently needed services.

Inpatient Services Covered During a Non-Covered Inpatient Stay			
Inpatient X-rays and Other Radiology Services	You pay: $0 copay for Medicare covered X-rays. $100 copay for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.	You pay: 10% coinsurance for Medicare covered X-rays. 20% coinsurance for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.	You pay: $10 copay for Medicare covered X-rays. $100 copay for diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website www.hne.com/medicare.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask HNE Medicare Premium (HMO) to make an exception** to cover the drug. We encourage current members to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of HNE Medicare Premium (HMO) year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by HNE Medicare Premium (HMO) or ask HNE Medicare Premium (HMO) to make an exception for you and cover your current drug.

Current formulary exceptions granted to you under HNE Medicare Premium (HMO) for 2015 will be valid only until the end of the plan year. You must submit a new request for a formulary exception for the 2016 plan year.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30th, 2015, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are on the back cover of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2015 (this year)	2016 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage.*

Stage	2015 (this year)	2016 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: Tier 1 (Generic drugs): You pay $10 per prescription. Tier 2 (Brand/Preferred drugs): You pay $45 per prescription. Tier 3 (Brand/Non-Preferred drugs): You pay $90 per prescription. Tier 4 (specialty drugs): You pay 33% of the total cost. _____ Once your total drug costs have reached $2,960, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: Tier 1 (Generic drugs): You pay $10 per prescription. Tier 2 (Brand/Preferred drugs): You pay $45 per prescription. Tier 3 (Brand/Non-Preferred drugs): You pay $90 per prescription. Tier 4 (specialty drugs): You pay 33% of the total cost. _____ Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Other Changes

	2015 (this year)	2016 (next year)
Telehealth Services - Teladoc	Limited telehealth services provided through providers in CMS defined limited access areas.	Telehealth services provided by Teladoc will be available to all Health New England Medicare Advantage members.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in HNE Medicare Premium (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2016.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2016 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan.
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program (SHIP) (see Section 6, or call Medicare (see Section 82).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, HNE Medicare Advantage offers other Medicare health plans and/or Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HNE Medicare Premium (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HNE Medicare Premium (HMO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1.877.486.2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2016.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.* If you enrolled in a Medicare Advantage plan for January 1, 2016, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

In Massachusetts, the SHIP is called Serving the Health Information Needs of Elders (SHINE).

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 413.750.2893 or 1.800.AGE.INFO (1.800.243.4636). TTY: 413.787.6154. You can learn more about SHINE by visiting their website (http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75 % or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1.800.325.0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Massachusetts has a program called Prescription Advantage that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 6 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Massachusetts HIV Drug Assistance Program – HDAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HDAP toll-free at 1-800.228.2714.

SECTION 8 Questions?

Section 8.1 – Getting Help from HNE Medicare Premium (HMO)

Questions? We're here to help. Please call Member Services at 1.413.787.0010 or toll free at 1.877.443.3314 (TTY only, call 1.800.439.2370). We are available for phone calls from 8:00 a.m. to 8:00 p.m., Monday through Friday. Calls to these numbers are free. (October 1 through February 14: 8:00 a.m. to 8:00 p.m., seven days a week.)

Read your 2016 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2016. For details, look in the 2016 *Evidence of Coverage* for HNE Medicare Premium (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.hne.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1.800.MEDICARE (1.800.633.4227)

You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Visit the Medicare website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans”).

Read Medicare & You 2016

You can read *Medicare & You 2016* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or 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.

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 1-413-787-0010. 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 1-413-787-0010. 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 1-413-787-0010。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 1-413-787-0010。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 1-413-787-0010. 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 1-413-787-0010. 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 quí vị cần thông dịch viên xin gọi 1-413-787-0010 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-413-787-0010. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-413-787-0010 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 1-413-787-0010. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-314-787-0100. سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

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