

# 2017 Summary of Benefits

Humana Gold Plus<sup>®</sup>  
SNP-DE H1036-167 (HMO SNP)

Charlotte  
Charlotte Metro Area



**Humana**<sup>®</sup>



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Our service area includes the following county/counties in North Carolina: Anson, Burke, Cabarrus, Caldwell, Catawba, Gaston, Iredell, Mecklenburg, Rowan, Stanly, NC;.



# Let's talk about **Humana Gold Plus<sup>®</sup>** **SNP-DE H1036-167 (HMO SNP)**

Find out more about the Humana Gold Plus SNP-DE H1036-167 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H1036-167 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the North Carolina Division of Medical Assistance Medicaid Program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is 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. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). Humana Gold Plus SNP-DE H1036-167 (HMO SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute- and chronic-care management, telephonic and in-person health support; assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

## To be eligible

To enroll in Humana Gold Plus SNP-DE H1036-167 (HMO SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the North Carolina Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H1036-167 (HMO SNP) may enroll dual eligibles who are FBDE, SLMB Plus, QMB Plus and QMB.

## Plan name:

Humana Gold Plus SNP-DE H1036-167 (HMO SNP)

## More about Humana Gold Plus SNP-DE H1036-167 (HMO SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicare benefits, your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.

## How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's customer service department or your state Medicaid office for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

### October 1 - February 14:

Call 7 days a week from 8 a.m. - 8 p.m.

### February 15 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website: **Humana-medicare.com**.

For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at <http://www.ncdhhs.gov/dma/medicaid/medicare.htm> or call the Medicaid Hotline at **1-800-662-7030**.



## A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

**This document is available in other formats** such as Braille and large print. This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364 (TTY: 711). Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).



## Monthly Premium, Deductible and Limits

<b>Monthly premium</b>	<b>\$0</b>
<b>Medical deductible</b>	This plan does not have a deductible.
<b>Pharmacy (Part D) deductible</b>	This plan does not have a deductible.
<b>Maximum out-of-pocket responsibility</b>	<b>\$6,700</b> in-network The most you pay for copays, coinsurance and other costs for medical services for the year.



## Covered Medical and Hospital Benefits

**For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services.**

	<b>WHAT YOU PAY ON THIS HUMANA PLAN</b>	<b>MEDICAID USUAL LIMITS AND COPAYS</b>
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
	<b>\$0</b> copay	
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care Physician (PCP)</b>	<b>\$0</b> copay	<b>\$3</b> copay for Medicaid-covered services
<b>Specialists</b>	<b>\$0</b> copay	<b>\$3</b> copay for Medicaid-covered services
<b>PREVENTIVE CARE</b>		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	<b>Covered at no cost</b> when you see an in-network provider.	• <b>\$3</b> copay for mammograms, pap smears and pelvic exams
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	<b>\$0</b> copay	

*You do not need a referral to receive covered services from in-network providers.*

*Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."*



## Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
<b>Urgently needed services</b>	<b>\$0</b> copay	
Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.		
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic Mammography</b>	<b>\$0</b> copay	
<b>Diagnostic radiology</b>	<b>\$0</b> copay	
<b>Lab services</b>	<b>\$0</b> copay	
<b>Diagnostic tests and procedures</b>	<b>\$0</b> copay	
<b>Outpatient X-rays</b>	<b>\$0</b> copay	
<b>Radiation Therapy</b>	<b>\$0</b> copay	
<b>HEARING SERVICES</b>		
<b>Medicare covered hearing</b>	<b>\$0</b> copay	
<b>Routine hearing</b>	<ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for fitting/evaluation, routine hearing test up to 1 per year.</li> <li>• <b>\$1000</b> maximum benefit coverage amount for Hearing Aids (all types) up to 1 every 3 years.</li> </ul>	

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
<b>DENTAL SERVICES</b>		
<b>Medicare covered dental</b>	<b>\$0</b> copay	
<b>Routine dental</b>	<ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 1 per year.</li> <li>• <b>\$0</b> copayment for Bitewing X-rays up to 1 set(s) per year.</li> <li>• <b>50%</b> coinsurance for Amalgam Filling, Periodontal Maintenance up to 1 per year.</li> <li>• <b>70%</b> coinsurance for Scaling and Root Planing (Deep Cleaning) up to 1 per year.</li> <li>• <b>\$0</b> copayment for Necessary Anesthesia with Covered Service up to unlimited per year.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$3</b> copay (only one copay for services that require more than one visit)</li> <li>• Some services require prior approval</li> </ul>
<b>VISION SERVICES</b>		
<b>Medicare covered vision services</b>	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>• <b>\$3</b> copay (Note: Effective 10-1-2011 non-covered for adults)</li> </ul>
<b>Glaucoma screening</b>	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>• Visits are counted toward your 22 doctor visit limit per year</li> </ul>
<b>Eyewear (post-cataract)</b>	<b>\$0</b> copay	
<b>Routine vision</b>	<ul style="list-style-type: none"> <li>• <b>\$0</b> copayment for Routine Exam, which includes refraction, up to 1 per year.</li> <li>• <b>\$200</b> maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames.</li> <li>• Includes ultraviolet protection and scratch resistant coating.</li> </ul>	
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>• <b>\$3</b> copay for Outpatient Medicaid-covered services</li> </ul>
<b>Outpatient group and individual therapy visits</b>	<b>\$0</b> copay	

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
<b>SKILLED NURSING FACILITY</b>		
Your plan covers up to 100 days in a SNF	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>Medicaid covers additional days beyond Medicare 100 day limit</li> </ul>
<b>REHABILITATION SERVICES</b>		
<b>Physical, occupational and speech therapy</b>	<b>\$0</b> copay	
<b>Cardiac and pulmonary rehabilitation</b>	<b>\$0</b> copay	
<b>AMBULANCE</b>		
<b>Ambulance (ground)</b>	<b>\$0</b> copay	
<b>Ambulance (air)</b>	<b>\$0</b> copay	
<b>TRANSPORTATION</b>		
	<b>\$0</b> copay for up to 24 one-way trips to plan approved locations. Not to exceed 25 miles per trip.	<ul style="list-style-type: none"> <li><b>\$0</b> copay to Medicaid-covered services</li> </ul>
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare covered foot care</b>	<b>\$0</b> copay	<ul style="list-style-type: none"> <li><b>\$3</b> copay for Medicaid-covered services</li> </ul>
<b>Routine foot care</b>	<b>0%</b> per visit for up to 6 visits	
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>\$0</b> copay	
<b>Medical Supplies</b>	<b>\$0</b> copay	
<b>Prosthetics (artificial limbs or braces)</b>	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>Prescription footwear coverage is limited to treatment of diabetics or when shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21</li> </ul>
<b>Diabetes monitoring supplies</b>	<b>\$0</b> copay	
<b>FITNESS AND WELLNESS</b>		
	<p>SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.</p> <p>The plan covers more benefits that promote health and well-being. To see more benefits, check out “More benefits with your plan,” listed later in this document.</p>	

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called “prior authorization” or “preauthorization.”

 Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
<b>MEDICARE PART B DRUGS</b>		
<b>Chemotherapy drugs</b>	<b>\$0</b> copay	
<b>Other part B drugs</b>	<b>\$0</b> copay	
<b>PRESCRIPTION DRUGS</b>		
<b>Medicare Part D Drugs</b>	See chart below for plan coverage information for prescription drugs	Medicaid may cover some drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage. <ul style="list-style-type: none"> <li>• <b>\$0.50 - \$3</b> copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.</li> </ul>
Initial coverage (after you pay your deductible, if applicable)		
<b>30-day supply</b>		
<b>For generic drugs (including brand drugs treated as generic), either:</b>	<b>\$0</b> copay; or <b>\$1.20</b> copay; or <b>\$3.30</b> copay	
<b>For all other drugs, either:</b>	<b>\$0</b> copay; or <b>\$3.70</b> copay; or <b>\$8.25</b> copay	
<b>90-day supply</b>		
<b>For generic drugs (including brand drugs treated as generic), either:</b>	<b>\$0</b> copay; or <b>\$1.20</b> copay; or <b>\$3.30</b> copay	
<b>For all other drugs, either:</b>	<b>\$0</b> copay; or <b>\$3.70</b> copay; or <b>\$8.25</b> copay	

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 am. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our “Evidence of Coverage” online.

If you reside in a long-term care facility, you pay the same as at a standard 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**

Unless otherwise specified, you can get your Part D medicine in the following days' supply amounts:

- 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)

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$4,950**, you pay nothing for all drugs.

 **Additional Medicaid Covered Services**

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the North Carolina Division of Medical Assistance Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call: 1-800-662-7030.

**BENEFITS****WHAT YOU PAY ON THIS  
HUMANA PLAN****MEDICAID STATE PLAN****PRODUCTS AND DEVICES****Dentures**

See "Dental" benefit in the "Covered Medical and Hospital Benefits" chart above

- **\$0** copay

**Eyeglasses**

See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above

- **\$0 - no copays for children**
- Contact lenses covered in special circumstances
- Prior approval required for all visual aids
- **\$3** copay for Medicaid vision services
- **\$2** copay for optical repair over \$5
- **\$2** copay for optical supplies

<b>Hearing Aids</b>	See “Hearing” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> <li>• Under age 21 only</li> <li>• 1 monaural or binaural hearing aid covered with prior approval</li> <li>• Replacements based on medical necessity and require prior approval</li> <li>• Supplies related to hearing aid are covered with prior approval</li> <li>• Batteries are covered</li> </ul>
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## TRANSPORTATION

<b>Non-Emergency Medical Transportation Services</b>	See “Transportation” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> <li>• Prior scheduling required</li> </ul>
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## INPATIENT LONG TERM CARE SERVICES

<b>Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older</b>	Not covered	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul>
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<b>Inpatient Psychiatric Services, under age 21</b>	See “Mental Health” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul>
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<b>Intermediate Care Facility Services for the Mentally Retarded</b>	Not Covered	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul>
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<b>Nursing Facility Services, other than in an Institution for Mental Diseases</b>	See “Skilled Nursing” benefit in the “Covered Medical and Hospital Benefits” chart above	<ul style="list-style-type: none"> <li>• <b>\$0</b> copay</li> </ul>
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## Other Medicaid Covered Services

<b>Outpatient Surgery</b>	<b>\$0</b> copay	<ul style="list-style-type: none"> <li>• <b>\$3</b> copay for Medicaid-covered services</li> </ul>
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<b>Over-the-Counter (OTC) benefit</b>	See “Over-the-Counter benefits” on the “More benefits with your plan” page later in this document	<ul style="list-style-type: none"> <li>• Certain OTC drugs are covered.</li> </ul>
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<b>Chiropractic Services</b>	Medicare-covered Chiropractic Services: <b>\$0</b> copay	<ul style="list-style-type: none"> <li>• <b>\$2</b> copay for Medicaid-covered services</li> </ul>
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## HOME AND COMMUNITY BASED WAIVER SERVICES

Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact Medicaid at 1-800-662-7030.

The Additional Medicaid Covered Services table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2016. All Medicaid covered services are subject to change at any time. For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at <http://www.ncdhhs.gov/dma/medicaid/medicare.htm> or call the Medicaid Hotline at 1-800-662-7030.



## More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

### **Additional smoking cessation**

A smoking cessation program available on-line, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

### **Chiropractic services**

Medicare-covered Chiropractic Services:

**\$0** copay

Routine Chiropractic Services:

- **0%** per visit for up to 12 visits

### **Counseling**

Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

### **Enhanced nutrition therapy**

Additional one-on-one nutrition therapy counseling.

### **Health education**

One-on-one wellness coaching with email, phone and online chat options.

### **Meals**

Well Dine Meal Program - Humana's meal program for members with certain special needs plan (SNP) specific conditions or following an inpatient stay in the hospital or nursing facility

### **HumanaFirst nurse advice line**

Health advice from a registered nurse, available 24 hours a day, seven days a week.

### **Over-the-counter allowance**

**\$0** copay; up to **\$15** monthly value for the purchase of OTC supplies from Humana Pharmacy mail delivery.

### **Go365™ by Humana**

Rewards for completing preventive health screenings and activities.



## Find out **more**

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You can see our plan's **provider and pharmacy directory** at our website at [www.humana.com/members/tools](http://www.humana.com/members/tools) or call us at the number listed at the beginning of this booklet and we will send you one.



You can see our plan's **drug formulary** at our website at [www.humana.com/medicare/medicare\\_prescription\\_drugs/medicare\\_drug\\_tools/medicare\\_drug\\_list/](http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/) or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2018 based on a review of Humana's Model of Care.

Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for more details.

The provider/pharmacy network may change at any time. You will receive notice when necessary.

## **Discrimination is Against the Law**

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. (“Humana”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- 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
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana 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:

Dr. Michelle M. Griffin, PhD (FACHE)

Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269

Email: Mgriffin5@humana.com or Accessibility@humana.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

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

1-800-368-1019 800-537-7697 (TDD)

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

# Multi-Language Interpreter Services

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (TTY: 711).

**繁體中文 (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 1-800-457-4708 (TTY: 711)。

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 (TTY: 711).

**한국어 (Korean):** 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 (TTY: 711)번으로 전화해 주십시오 .

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (TTY: 711).

**日本語 (Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-457-4708 (TTY: 711) まで、お電話にてご連絡ください。

**فارسی (Farsi):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-457-4708 (TTY: 711)

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).





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