

Core NH Four-Tier

# **Prescription Drug Brochure**

This brochure is a legal document that explains the prescription drug benefits provided by Harvard Pilgrim Health Care of New England, Inc. (HPHC-NE) to Members with plans that include outpatient pharmacy coverage.

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# I. PRESCRIPTION DRUG COVERAGE

Prescription medications can play an important role in keeping you healthy. Your coverage includes an outpatient prescription drug benefit to help make paying for these medications more affordable. This benefit covers outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

- |                                 |  |
|---------------------------------|--|
| • Our prescription drug benefit | • Where to buy your prescriptions            |
| • General Member Cost Sharing   | • Our Mail Service Prescription Drug Program |
| • Covered and non-covered drugs | • Drug coverage policies                     |

You will find words in this brochure that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this brochure are defined in the Glossary in your Benefit Handbook.

Your benefits are administered on a Calendar Year basis.

## A. Four-Tier Prescription Drug Benefit

We place all covered drugs into one of four levels or "tiers." Each tier has its own Member Cost Sharing, which is listed on your identification (ID) card and Schedule of Benefits. Medications listed in tier 1 will always have the lowest Member Cost Sharing and medications in Tier 4 will always have the highest Member Cost Sharing.

**Please Note:** There are a limited number of medical drugs/supplies identified on the Prescription Drug List with the status of **Medical-Covered** (i.e. spacer for asthma treatment). These are covered under your medical benefits and may be obtained at a retail pharmacy. To find out if a medical drug/supply is covered, simply go online to the prescription drug list and search for the item. If it is covered, it will have a status of "Medical-Covered".

## B. The Prescription Drug List

The Prescription Drug List identifies all outpatient prescription drugs covered by the Plan. To get a copy of the Core NH Four-Tier Prescription Drug List, visit [www.harvardpilgrim.org](http://www.harvardpilgrim.org) and log into **your secure online account** or call the Member Services Department at **1-877-907-4742**.

## C. Member Cost Sharing

This section describes how we administer the different types of Member Cost Sharing under your outpatient prescription drug benefit.

Similar to your medical coverage, Members are required to share the cost of the benefits provided under the Plan.

Your Member Cost Sharing may include a combination of Copayments, Coinsurance or a Deductible. For the Member Cost Sharing amounts that apply to your Plan, please see your ID card and Schedule of Benefits.

### Discount Rate

In this brochure, we refer to the term “Discount Rate.” The Discount Rate is a price for prescription drugs that has been negotiated with participating pharmacies. The Discount Rate is the basis for calculating your Member Cost Sharing.

**Note:** The Discount Rate is not a fixed discount. It may be modified as market conditions change. Our cost for covered drugs is generally lower than the Discount Rate.

### How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price pharmacies charge for drugs. If a participating pharmacy’s retail price is less than the Discount rate, your Member Cost Sharing is always based on the lower amount.

### Copayments

Some plans provide prescription drug coverage with Copayments. Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Different Copayment amounts usually apply to each of the drug tiers.

#### What You Pay

Copayments are calculated in two ways, depending on whether you use a participating or non-participating pharmacy:

#### Participating Pharmacy

If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy’s retail price for the drug.

#### Non-Participating Pharmacy

If you buy your prescriptions at a non-participating pharmacy, you pay the lower of the Copayment or the pharmacy’s retail price for the drug.

Please see “Buying Prescriptions” for more information on participating and non-participating pharmacies.

#### What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill, except where limited by us. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. We may limit the quantity of a drug available per 30-day period or per Copayment.

### Coinsurance

Some plans provide prescription drug coverage with Coinsurance. With Coinsurance, you pay percentage payments for a drug, instead of fixed dollar amounts.

#### What You Pay

Coinsurance is calculated in two ways, depending on whether you use a participating or non-participating pharmacy.

**Participating Pharmacy**

If you buy your prescriptions at a participating pharmacy, your Coinsurance payment is calculated using the lower of the Discount Rate or the pharmacy's retail price for the drug.

**Non-Participating Pharmacy**

If you buy your prescriptions at a non-participating pharmacy, your Coinsurance payment is calculated using the pharmacy's retail price for the drug.

The Coinsurance percentage is multiplied by the Discount Rate or the pharmacy's retail price, as applicable, to arrive at your out-of-pocket Coinsurance payment. Coinsurance is calculated the day the pharmacy fills the prescription and the Coinsurance is paid to the pharmacy at the time of purchase.

✓ FOR EXAMPLE: If the participating pharmacy's retail price is \$150 but the Discount Rate is \$100, your Coinsurance amount is based on the Discount Rate of \$100. If your Coinsurance is 20%, your Member Cost Sharing will be \$20.

Some plans include a maximum Coinsurance amount. If your Plan includes a per prescription maximum amount, your per prescription Coinsurance payment is limited to that maximum.

Please see "Buying Prescriptions" for more information on participating and non-participating pharmacies.

**Deductibles**

Your Plan may include a Deductible.

A Deductible is a specific dollar amount that you pay each Calendar Year for certain covered services before any coverage is available for those services. If a Deductible applies to your coverage, you must first pay the Deductible amount for the purchase of prescription drugs before any coverage for drugs begins for the Calendar Year.

Please see your ID card and Schedule of Benefits to see if a Deductible applies to your Plan.

**What You Pay****Participating Pharmacy**

When you use a participating pharmacy, you pay the lower of the Discount Rate or the pharmacy's retail price for prescriptions until the Deductible is met.

**Non-Participating Pharmacy**

When you use a non-participating pharmacy, you pay the pharmacy's retail price for prescriptions until the Deductible is met.

If the Discount Rate or retail price for a prescription, as applicable, exceeds the balance remaining on the Deductible for the Calendar Year, you are required to pay the balance of the Deductible and the applicable Copayment. If Coinsurance applies, you are required to pay the applicable Coinsurance percentage on any amount exceeding the Deductible. You are never obligated to pay any combination of Copayments, Coinsurance or Deductible amounts that exceed the lower of the Discount Rate or the pharmacy's retail price for the drug.

The Deductible amount is applied the day the pharmacy fills the prescription and is paid to the pharmacy at the time of purchase.

### Where the Deductible Applies

The Deductible may apply to drugs in any Tier. Please see your ID card and Schedule of Benefits for the amount of your Deductible and the tiers to which it applies. Once you have met your Deductible for the Calendar Year, drugs are covered for the rest of the Calendar Year, subject to the applicable Copayment or Coinsurance.

✓ FOR EXAMPLE: If your Plan has a \$100 Deductible and you have a claim with a discount rate of \$200, you will be responsible for the first \$100 to satisfy your Deductible requirement before we begin to pay benefits.

### Preventive Medications with a High Deductible Health Plan

If you have a High Deductible Health Plan, your Deductible may not apply to certain medications used for preventive care. These medications have been selected by the Plan because they are often used to lower the risk of illness. In some cases these medications are prescribed for people who have developed risk factors for an illness that has not yet manifested itself. In others it may be to prevent the recurrence of an illness from which the Member has recovered. Please see your Schedule of Benefits to determine if you have this coverage.

If your Plan exempts preventive medications from the Deductible and your health care provider prescribes one of the designated preventive medications, the Deductible will not apply to that prescription. However, you will be required to pay the applicable Copayment or Coinsurance amount for the drug. Since no Deductible applies to preventive medications, expenses you incur for such drugs do not apply to your In-Network Deductible.

The Plan may change the listing of designated preventive medications from time to time. To find out if your medication is one of the designated preventive medications, visit **[www.harvardpilgrim.org](http://www.harvardpilgrim.org)** and log into **your secure online account**.

The preventive medications described above are separate from the preventive care services, including drugs, for which no Member Cost Sharing applies as required by the Affordable Care Act.



### **Out-of-Pocket Maximum**

Your Plan provides prescription drug coverage with an Out-of-Pocket Maximum. Your Out-of-Pocket Maximum applies to both medical and prescription Member Cost Sharing. The Out-of-Pocket Maximum is the total amount you are required to pay in Member Cost Sharing. Your Out-of-Pocket Maximum will be stated on your Schedule of Benefits.

Participating pharmacies will not charge you Member Cost Sharing once you have reached your Out-of-Pocket Maximum.

## II. WHAT IS COVERED

Your prescription drug benefit covers select Medically Necessary drugs that require a prescription by law, except drugs we exclude or limit. Your benefit also covers the non-prescription items listed below when you have a prescription. All covered drugs are subject to the applicable Member Cost Sharing.

Your Plan covers the following prescription and non-prescription items:

Covered Prescription Drugs (when listed on the Prescription Drug List)	Covered Non-Prescription Items
<ul style="list-style-type: none"> <li>FDA approved prescription drugs prescribed by a physician and listed as covered in the Prescription Drug List</li> <li>Needles and syringes needed to administer covered drugs</li> <li>Epinephrine auto-injectors</li> <li>FDA approved contraceptive drugs and devices</li> <li>Prenatal vitamins</li> <li>FDA approved hormone replacement therapy (HRT)</li> <li>Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS when recognized by established research documentation</li> <li>Compounded prescriptions are covered if: (1) the Member is under the age of 18 or HPHC has given Prior Approval for coverage of the compound, (2) the active ingredients are listed in the Prescription Drug List, and (3) one or more agents within the compound is FDA approved and requires a prescription</li> </ul>	<ul style="list-style-type: none"> <li>Insulin</li> <li>Oral agents for controlling blood sugar</li> <li>Lancets</li> <li>Blood glucose testing strips</li> <li>Urine diabetic testing strips</li> <li>Ketone diabetic testing strips</li> <li>Certain over-the-counter drugs that are an alternative to a prescription drug when listed as covered on the Prescription Drug List</li> <li>Certain women's contraceptives</li> </ul> <p><b>Please Note:</b> If you are a Medicare member, the items listed above may be covered by your Medicare Part B coverage.</p>

**Please Note:** No Member Cost Sharing applies to certain preventive care services, including FDA approved contraceptive drugs and devices, oral fluoride for children up to age five, and folic acid for women planning or capable of pregnancy. A Member may receive a 12 month supply of an FDA approved prescription contraceptive per Calendar Year in accordance with state law. Please go to [www.harvardpilgrim.org](http://www.harvardpilgrim.org) to see a complete list of covered preventive services.

## III. BUYING PRESCRIPTIONS

### A. Participating Pharmacies

It's easier and often less expensive to fill prescriptions at a participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your ID card and pay the applicable Member Cost Sharing amount. If you do not use a participating pharmacy, you must pay the retail price for the medication and submit a claim for reimbursement.

There are over 67,000 participating pharmacies in the United States, including:

<ul style="list-style-type: none"> <li>• CVS/pharmacy</li> <li>• Kmart Pharmacy</li> <li>• Rite Aid</li> <li>• Stop &amp; Shop</li> </ul>	<ul style="list-style-type: none"> <li>• Target Pharmacy</li> <li>• Walgreens</li> <li>• Walmart</li> <li>• Many independent drug stores</li> </ul>
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You can get more information on participating pharmacies by using our website at [www.harvardpilgrim.org/rx](http://www.harvardpilgrim.org/rx) or by calling our Member Services Department at **1-877-907-4742**.

## B. The Specialty Pharmacy Program

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for Members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time and it is delivered directly to the Member's home via mail. This is NOT part of the Mail Service Prescription Drug Program. Extended day supplies and Copayment savings do not apply to these designated specialty drugs. To find out if your medication needs to be obtained at a specialty pharmacy, visit [www.harvardpilgrim.org](http://www.harvardpilgrim.org) and log into **your secure online account**.

## C. Non-Participating Pharmacies

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and submit a claim for reimbursement. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus your applicable Member Cost Sharing. Payment will be limited to the Allowed Amount for the drug.

In the case of HMO coverage plans, no benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

## D. 90-Day Prescription Drug Benefit at a Pharmacy

You may purchase up to a 90-day supply of maintenance medications from a participating pharmacy. When you obtain a 90-day prescription you will pay the equivalent of three monthly Member Cost Sharing payments. Although most maintenance medications are available for a 90-day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90-day supply.

## E. Mail Service Prescription Drug Program

We provide a Mail Service Prescription Drug Program for Members who prefer the convenience of receiving their prescriptions through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Program. In addition to saving a trip to the pharmacy, some plans provide lower Member Cost Sharing amounts for drugs purchased through the Mail Service program.

Although most maintenance medications are available from the Mail Service Program, we may exclude drugs from the program for clinical reasons or to prevent potential waste. In addition,

drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

Please see your Schedule of Benefits for your Mail Service Member Cost Sharing.

For more information about the Plan's Mail Service Prescription Drug Program, please call 1-855-258-1561 (TTY 711).

## F. Medication Synchronization Program

The Medication Synchronization Program allows multiple prescriptions to be aligned for refill to the same date. This program applies only to medications for chronic conditions. In order to synchronize your prescription, medications may be dispensed in split fills with less than a month's supply of the medication filled at a time.

In these instances, you will be responsible for paying a pro-rated Member Cost Sharing amount instead of the Member Cost Sharing normally paid for a full 1-30 day supply. The Medication Synchronization Program permits and applies a prorated daily cost sharing rate to covered maintenance prescription drugs that are:

- dispensed by a participating pharmacy;
- in a quantity less than thirty (30) days' supply; and
- used for the management or treatment of a chronic, long-term condition.

Medication synchronization is limited to one per Calendar Year per maintenance prescription drug. Prescription drugs excluded from this program include, but are not limited to, controlled substances, pain medications, and antibiotics.

You can get more information on this program by visiting our website at [www.harvardpilgrim.org/rx](http://www.harvardpilgrim.org/rx) or by calling our Member Services Department at 1-877-907-4742

## IV. WHAT IS NOT COVERED OR HAS LIMITED COVERAGE

There are a number of prescription drugs that are not covered, are subject to quantity limits or require Prior Authorization.

We cover only drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy. Drugs that are not covered include drugs that are not listed in the Prescription Drug List or are listed as non-formulary. If your doctor feels that one of the non-formulary drugs is needed, your doctor can submit a request for coverage under the exception process. Please see section *IV.B. Exception Process* for more information.

We limit the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on the quantity of certain drugs we cover.

We require Prior Authorization to evaluate whether certain drugs are Medically Necessary. Prior Authorization is based on clinical criteria and may include: (1) an evaluation of whether a drug is clinically appropriate for the medical condition for which it has been prescribed; or (2) whether "step therapy" will be required. Drugs subject to step therapy are only covered if a Member has either tried another drug to treat a specific condition or obtained Prior Authorization to be exempted from that requirement. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines for a drug for which coverage is requested by visiting our website at [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or by calling Member Services at 1-877-907-4742.

Drugs that are covered, subject to quantity limits, or require Prior Authorization are listed in the Prescription Drug List. We may add to the list of drugs for which Prior Authorization is required or for which coverage is excluded or limited at any time. You may view the most current copy of this list by visiting [www.harvardpilgrim.org](http://www.harvardpilgrim.org) and logging into **your secure online account**. You may also request a copy of this list by calling the Member Services Department at **1-877-907-4742**.

### **Exclusions from Coverage**

No coverage is provided under this prescription drug brochure for the following:

- Drugs not listed in the Prescription Drug List.
- Drugs listed as non-formulary in the Prescription Drug List.
- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs for the treatment of infertility.
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.)
- Non-prescription items, other than those specifically listed under "What is Covered."
- Drugs that have not been approved by the FDA. (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation.)
- Experimental drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Drugs prescribed as part of a course of treatment that we do not cover.
- Drugs provided to you anywhere other than an outpatient pharmacy. (See your Benefit Handbook for an explanation of the limited coverage available for medications received from physicians and other non-pharmacy providers.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies.
- In the case of HMO coverage plans, no benefits are provided for medications prescribed by providers who are not authorized to do so by us or for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.
- Any sales tax or governmental assessment on pharmacy items.
- Compounded prescriptions unless (1) the Member is under the age of 18 or HPHC has given Prior Approval for the compound, (2) the active ingredients are listed in the Prescription Drug List, and (3) one or more agents within the compound is FDA approved and requires a prescription.
- Digital therapeutics and prescription digital therapeutics (PDTs), unless specifically listed as covered under the Plan. Please see the Prescription Drug List and your other member materials to determine if your Plan provides this coverage.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for children).

## **A. Prior Authorization**

Certain drugs require Prior Authorization for coverage under the Plan. These include compounded drugs for Members over the age of 18. Your prescribing provider may request Prior Authorization by completing the form found online at [www.harvardpilgrim.org/pharmacycriteria](http://www.harvardpilgrim.org/pharmacycriteria) and faxing it

to 1-617-673-0988. We will respond to the Prior Authorization request within 2 business days from the date we receive a completed form. If we do not respond to the request within 2 business days after receiving the completed form, the request will be approved.

If you have any questions regarding this process, please contact the Member Services Department at 1-877-907-4742.

## B. Exception Process

Your Plan has an exception process you may use to ask us to provide coverage for New-to-Market or non-formulary drugs, or drugs that are subject to Prior Authorization, step therapy, or quantity limitations. Drugs are excluded from coverage if they are listed as non-formulary or are not listed in the Prescription Drug List.

**Note:** Drugs approved through the Exception Process may be subject to the highest Member Cost Sharing.

If you have a High Deductible Health Plan where the Deductible does not apply to certain medications for preventive care, you may use the exception process to request that we waive the Deductible for drugs not identified by HPHC as a preventive drug. Your Schedule of Benefits will indicate if you have this coverage. Please see the section titled, "Deductibles", above, for more information on the preventive drug benefit.

We will only grant exceptions for clinical reasons. Your prescribing provider must give us a statement that explains why an exception is Medically Necessary, including why the covered drugs on the Prescription Drug List are not as effective as the requested drug. We will act on a request for an exception within 48 hours of receiving your prescribing provider's statement of the reasons an exception is Medically Necessary. If you request an exception for a medically necessary prescription drug that is non-formulary or limited by the Plan and we do not respond to your request within 48 hours after receiving the clinical rationale from your prescribing provider, your request will be approved.

You may request an **expedited exception** when one of the following situations occurs:

- you could seriously jeopardize your life, health or ability to regain maximum function if there is a delay in treatment, or
- you are undergoing a current course of treatment using a non-formulary drug

We will notify you of a decision no later than 24 hours after receiving your expedited request.

You or your prescribing provider may request an exception by completing the form found online at [www.harvardpilgrim.org/pharmacycriteria](http://www.harvardpilgrim.org/pharmacycriteria) and fax it to 1-617-673-0988. If you have any questions regarding this process, please contact the Member Services Department at 1-877-907-4742.

Your request for an exception will be considered by pharmacists and other appropriate practitioners. If we deny your request, we will tell you the reason for the denial and explain the process for requesting an appeal of our decision.

## V. ABOUT YOUR DRUG BENEFIT

### A. Pharmacy and Therapeutics Committee

Our Pharmacy and Therapeutics (P & T) Committee is an advisory group comprised of our clinical staff and of physician specialists, independent physicians, and pharmacy specialists that work together to promote clinically sound, cost effective pharmaceutical care.

The P&T Committee makes recommendations for tier placement of drugs, and limitations on drug coverage, as well as providing guidance on clinical criteria.

### B. Tier Changes

We regularly review and update the Prescription Drug List as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change each year. You can get an updated Prescription Drug List online at [www.harvardpilgrim.org](http://www.harvardpilgrim.org) by logging into **your secure online account**, or by calling the Member Services Department at **1-877-907-4742**.

### C. Deletions from Coverage

We may discontinue coverage of a drug identified on the Prescription Drug List or covered under this brochure. Generally, such changes will take place annually. In such event, we will send notice to Members who have received coverage for the drug or product during the 12-month period prior to the date of discontinuation. Such notice will be sent at least 60 days before discontinuing coverage for the drug or product unless the FDA has determined the drug or product to be unsafe.

### D. New-to-Market Drugs

New-to-Market drugs are reviewed for safety and clinical effectiveness by the Point32Health Pharmacy & Therapeutics Committee. We then make a coverage determination based on the Committee's recommendation. A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability. If the New-to-Market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

### E. Important Notice

In the event of a Medical Emergency, seek immediate care. You may call **911** or your local emergency number. Please see your Benefit Handbook and Schedules of Benefits for information on your emergency coverage.

### F. Incorporation with Benefit Handbook

This Prescription Drug Brochure incorporates the terms and conditions provided in your plan's Benefit Handbook including, but not limited to, appeals and grievance processes, utilization review procedures and coordination of benefits and subrogation policies.

Language Assistance Services

**Español (Spanish)** ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

**Português (Portuguese)** ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

**繁體中文 (Traditional 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 1-888-333-4742 (TTY: 711)。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

**العربية (Arabic)**  
إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1-888-333-4742 (TTY: 711)

**ខ្មែរ (Cambodian)** ចំណុចសំណើ: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

**Français (French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

**Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

**한국어 (Korean)** '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

**हिंदी (Hindi)** ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

**ગુજરાતી (Gujarati)** ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).



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U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TTY)

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



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