

# Schedule of Benefits

## Harvard Pilgrim Health Care, Inc.

### Standard Low Gold - Flex

### MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

#### Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria on our website at [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or by calling **1-888-888-4742**.

**Flex Providers** This Plan includes Flex Providers. A Flex Provider is a Plan Provider who provides certain outpatient services with lower Member Cost Sharing. When you receive these Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not listed as a Flex Provider. The table below identifies the outpatient services which may be obtained from a Flex Provider and the applicable Member Cost Sharing.

The Plan's Provider Directory lists all Plan Providers including those providers listed as a Flex Provider. You can access the Provider Directory at [www.harvardpilgrim.org](http://www.harvardpilgrim.org). You may also obtain a paper copy free of charge by calling the Member Services Department at **1-888-333-4742**.

#### Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment known as "Level 1," and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to most outpatient specialty care.

If a provider is categorized as both a Level 1 provider and a Level 2 provider, Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for a Level 1 Copayment.

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

#### Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the

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Member Services Department at **1-877-907-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician’s office, see “Physician and Other Professional Office Visits.” For services provided in a hospital emergency room, see “Emergency Room Care,” and for outpatient surgical procedures, please see “Surgery - Outpatient.”

<b>General Cost Sharing Features:</b>	<b>Member Cost Sharing:</b>
<b>Coinsurance and Copayments</b>	
	See the benefits table below
<b>Deductible</b>	
	\$2,000 per Member per Plan Year \$4,000 per family per Plan Year
<b>Deductible Rollover</b>	
	None
<b>Out-of-Pocket Maximum</b>	
– Includes all Member Cost Sharing	\$5,600 per Member per Plan Year \$11,200 per family per Plan Year

<b>Benefit</b>	<b>Member Cost Sharing:</b>
<b>Acupuncture Treatment for Injury or Illness</b>	
– Limited to 20 visits per Plan Year	\$50 Copayment per visit
<b>Ambulance Transport</b>	
Emergency ambulance transport	Deductible, then no charge
Non-emergency ambulance transport	Deductible, then no charge
<b>Autism Spectrum Disorders Treatment</b>	
Applied behavior analysis	Level 1: \$30 Copayment per visit
<b>Chemotherapy and Radiation Therapy</b>	
	Deductible, then no charge
<b>Dental Services</b>	
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then no charge
<b>If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.</b>	
<b>Dialysis</b>	
	Deductible, then no charge
<b>Durable Medical Equipment</b>	
Durable medical equipment	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge

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<b>Benefit</b>	<b>Member Cost Sharing:</b>
<b>Durable Medical Equipment (Continued)</b>	
Oxygen and respiratory equipment	No charge
<b>Early Intervention Services</b>	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
<b>Emergency Room Care</b>	
	Deductible, then \$350 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
<b>Hearing Aids (for Members up to the age of 22)</b>	
- Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance
<b>Home Health Care</b>	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
<b>Hospice – Outpatient</b>	
	Deductible, then no charge
<b>Hospital – Inpatient Services</b>	
Acute hospital care	Deductible, then \$750 Copayment per admission
Inpatient maternity care	Deductible, then \$750 Copayment per admission
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then \$750 Copayment per admission
Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then \$750 Copayment per admission
<b>Infertility Services and Treatments (see the Benefit Handbook for details)</b>	
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
<b>Laboratory, Radiology and Other Diagnostic Services</b>	
Laboratory	<b>Flex Providers</b> \$20 Copayment per visit <b>Other Plan Providers</b> Deductible, then \$50 Copayment per visit
Genetic testing	Deductible, then \$50 Copayment per visit
Radiology	Deductible, then \$75 Copayment per visit
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	<b>In a physician's office or non-hospital affiliated facility</b> \$200 Copayment per procedure <b>In a hospital or hospital affiliated facility</b> Deductible, then \$300 Copayment per procedure
Other diagnostic services	Deductible, then \$50 Copayment per visit

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<b>Benefit</b>	<b>Member Cost Sharing:</b>
<b>Low Protein Foods</b>	
	Deductible, then 20% Coinsurance
<b>Maternity Care - Outpatient</b>	
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge
Routine outpatient prenatal and postpartum care	No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under “Physician and Other Professional Office Visits” and Member Cost Sharing for an ultrasound billed as a specialized or non-routine services is listed under “Laboratory, Radiology and Other Diagnostic Services.”	
<b>Medical Drugs (drugs that cannot be self-administered)</b>	
Medical drugs received in a physician’s office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge
Some medical drugs received in a physician’s office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. Your Member Cost Sharing for outpatient prescription drugs is listed under the Prescription Drug section in this Schedule of Benefits.	
<b>Medical Formulas</b>	
	Deductible, then no charge
<b>Mental Health and Substance Use Disorder Treatment</b>	
Inpatient services	Deductible, then \$750 Copayment per admission
Intermediate care services	Deductible, then no charge
Outpatient group therapy	\$10 Copayment per visit
Outpatient treatment, including individual therapy, detoxification and medication management	Level 1: \$30 Copayment per visit
Outpatient methadone maintenance	No charge
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge
<b>Observation Services</b>	
	Deductible, then \$750 Copayment per observation stay
<b>Ostomy Supplies</b>	
	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)</b>	
Routine examinations for preventive care, including immunizations	No charge

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<b>Benefit</b>		<b>Member Cost Sharing:</b>	
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)</b>			
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.			
Consultations, evaluations and sickness and injury care		Level 1: \$30 Copayment per visit Level 2: \$55 Copayment per visit	
Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment level applies. Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."			
Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures		Deductible, then no charge	
Administration of allergy injections		Deductible, then no charge	
<b>Preventive Services and Tests</b>			
		No charge	
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . You may also get a copy of the Preventive Services notice by calling the Member Services Department at <b>1-877-907-4742</b> . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.			
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.		No charge	
<b>Prosthetic Devices</b>			
		Deductible, then 20% Coinsurance	
<b>Rehabilitation and Habilitation Services – Outpatient</b>			
Cardiac rehabilitation		Level 2: \$55 Copayment per visit	
Pulmonary rehabilitation therapy		Level 2: \$55 Copayment per visit	

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<b>Benefit</b>		<b>Member Cost Sharing:</b>	
<b>Rehabilitation and Habilitation Services – Outpatient (Continued)</b>			
Speech-language and hearing services		<b>In a physician’s office or non-hospital affiliated facility</b> \$25 Copayment per visit <b>In a hospital or hospital affiliated facility</b> \$55 Copayment per visit	
Rehabilitation Services – Physical and occupational therapies combined up to 60 visits per Plan Year Habilitation Services – Physical and occupational therapies combined up to 60 visits per Plan Year		<b>In a physician’s office or non-hospital affiliated facility</b> \$25 Copayment per visit <b>In a hospital or hospital affiliated facility</b> \$55 Copayment per visit	
Outpatient physical and occupational therapy is not subject to the limits listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.			
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>			
Colonoscopy, endoscopy and sigmoidoscopy		<b>Flex Providers</b> \$250 Copayment per visit <b>Other Plan Providers</b> Deductible, then \$500 Copayment per visit	
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>			
		\$50 Copayment per visit	
<b>Surgery – Outpatient</b>			
		<b>Flex Providers</b> \$250 Copayment per visit <b>Other Plan Providers</b> Deductible, then \$500 Copayment per visit	
<b>Telemedicine Virtual Visit Services - Outpatient</b>			
		Level 1: \$30 Copayment per visit Level 2: \$55 Copayment per visit	
For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.			
<b>Urgent Care Services</b>			
Doctors On Demand		No charge	
<b>Important Note:</b> Doctors On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctors On Demand, including how to access them, please visit our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .			
Convenience care clinic		Level 1: \$30 Copayment per visit	
Urgent care center		Level 2: \$55 Copayment per visit	
Hospital urgent care center		Level 2: \$55 Copayment per visit	
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."			
<b>Vision Services</b>			
Routine eye examinations limited to 1 exam per Plan Year		Level 1: \$30 Copayment per visit	
Vision hardware for special conditions		Deductible, then no charge	
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.			

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<b>Benefit</b>	<b>Member Cost Sharing:</b>
<b>Voluntary Sterilization in a Physician's Office</b>	
	Deductible, then no charge
<b>Voluntary Termination of Pregnancy</b>	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery- Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
<b>Wellness Reimbursement Benefits (see the Benefit Handbook for details)</b>	
<b>Fitness</b> – Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center <b>or</b> costs paid toward a fitness tracker as follows: – One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year <b>or</b> is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of \$150 per calendar year.* – A second Member is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of \$150 per calendar year.	No charge
*If a Member receives reimbursement for one month of individual or family fitness membership which is less than \$150, then the difference may be applied toward the cost of the Member's fitness tracker. If the cost of one month of individual or family fitness membership is greater than \$150, then the 1 month is covered in full and there is no further coverage available for that Member.	
<b>Weight management programs</b> – Coverage provided for 3 months of membership at Weight Watchers traditional meetings or Weight Watchers at Work programs per calendar year.	No charge
<b>Wigs and Scalp Hair Protheses</b>	
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance

### 3-Tier Value Outpatient Prescription Drug Coverage

<b>Benefit:</b>	<b>Member Cost Sharing:</b>
<b>Outpatient Prescription Drug Deductible</b>	
	\$250 per Member per Plan Year \$500 per family per Plan Year
<b>Your pharmacy Copayments for up to a 30-day supply are:</b>	
Tier 1:	\$25 Copayment per prescription or prescription refill
Tier 2:	Deductible, then \$50 Copayment per prescription or prescription refill
Tier 3:	Deductible, then \$125 Copayment per prescription or prescription refill
<b>Your pharmacy Copayments for up to a 90-day supply of maintenance medications at a retail pharmacy are:</b>	
Tier 1:	\$75 Copayment per prescription or prescription refill
Tier 2:	Deductible, then \$150 Copayment per prescription or prescription refill
Tier 3:	Deductible, then \$375 Copayment per prescription or prescription refill
<b>Harvard Pilgrim's mail service prescription drug program.</b>	
You may purchase a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program.	
Your mail service Copayments for a 90-day supply are:	
Tier 1:	\$50 Copayment per prescription or prescription refill
Tier 2:	Deductible, then \$100 Copayment per prescription or prescription refill
Tier 3:	Deductible, then \$375 Copayment per prescription or prescription refill
A summary of your cost sharing amounts for your prescription drug coverage is also listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. To obtain coverage for your prescription drugs bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the appropriate amount. Please refer to your Prescription Drug Brochure for detailed information about your coverage.	



## Pediatric VisionCare

Dependents under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 12 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

### (A) PRESCRIPTION EYEGLOSS FRAMES AND LENSES

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

The Plan will reimburse you for the first \$50 you pay toward covered prescription eyeglass frames and lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints, scratch proofing and progressive lenses. Coverage is also excluded for deluxe and designer eyeglass frames.

### (B) PRESCRIPTION CONTACT LENSES

The Plan will reimburse you for the purchase of your first order of prescription contact lenses up to the following amounts:

The Plan will reimburse you for the first \$50 you pay toward your first order of covered prescription contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Reimbursement for disposable contact lenses is limited to a 6 month supply.

In addition to the Covered Benefits described above, Dependents under the age of 19 are also eligible for the following:

### (C) MEDICALLY NECESSARY CONTACT LENSES

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear.

The Plan will reimburse you for the first \$50 you pay toward Medically Necessary contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

### (D) LOW VISION SERVICES

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. Covered low vision services will include (1) one comprehensive low vision evaluation every 5 years; (2) Medically Necessary visual aids such as high-power eyeglasses, magnifiers and telescopes; and (3) follow-up examinations as Medically Necessary.

See "Physician and Other Professional Office Visits" for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you for the first \$50 you pay toward

visual aids as described above. Thereafter, the Plan will reimburse you 50% of your remaining covered charges for visual aids.

### **OUT-OF-POCKET MAXIMUM**

All Member Cost Sharing under this benefit applies toward your annual Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the Out-of-Pocket Maximum amount that applies to your plan.

### **WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT**

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor. Only contact lenses may be purchased from an internet provider.

### **HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT**

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

1. Complete a member reimbursement form. You can obtain this form by visiting our website at [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or by calling the Member Services Department at **1-877-907-4742** to request a form. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:

**HPHC Claims  
P.O. Box 699183  
Quincy, MA 02269-9183**

We will reimburse you for your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

### **WHERE TO CALL WITH QUESTIONS**

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-877-907-4742**. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

### **EXCLUSIONS**

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies
- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons

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- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider.

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

**ខ្មែរ (Cambodian)** ចូលជូនដំណឹង: 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 मुफ्त में 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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີມີ້ພ້ອມໃຫ້ທ່ານ. ໂທສ 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)

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