Schedule of Benefits

The Harvard Pilgrim Access America Plan
MASSACHUSETTS

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

You will find words in this Schedule of Benefits 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 Schedule of Benefits are defined in the Glossary in your Benefit Handbook.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

The Harvard Pilgrim Access America Plan Provider Directory lists the Plan Providers you may use to obtain In-Network Benefits and is available online at site, **www.harvardpilgrim.org/GIC** or by calling the Member Services Department at **1-844-442-7324**. For TTY service, please call **711**.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount, unless it is a Surprise Bill. A Surprise Bill is an unexpected balance bill as defined by the federal No Surprise Act of 2022. Please note: Massachusetts also continues to enforce balance billing protections.

In a **Medical Emergency**, you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-844-442-7324** for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1-800-708-4414** for medical services
- **1-844-442-7324** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

Medical Necessity Guidelines

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 Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-844-442-7324**.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of In-Network office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received 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 covered outpatient professional services received from specialty care providers.

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

General Cost Sharing Features:	Member Cost Sharing:
Level 1 and Level 2 Copayments	
	PCP Copayment: $20 per visit Specialist Copayment: $45 per visit
In-Network Inpatient Hospital Copayments	
Medical care	$275 Copayment per admission
Mental health care (Including the treatment of substance use disorders)	$275 Copayment per admission
Please Note: There is an Inpatient Hospital Copayment maximum of one Medical or Mental Health Care inpatient Copayment per Member during each Quarter in a Plan Year.	
If you are readmitted to a medical hospital or mental health care hospital in a new Quarter, but within 30 calendar days of a discharge, your second Inpatient Hospital Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. This waiver is limited to a Plan Year basis. The bullets below list examples of when you can expect to pay a Inpatient Hospital Copayment and when you can expect that Copayment to be waived: • If you are admitted from March 2 until March 7, you are responsible for an Inpatient Hospital Copayment. If you are then readmitted from March 12 until March 15, the second Inpatient Hospital Copayment is waived because it is within the same Quarter as the first admission. • If you are admitted March 2 until March 7, and then readmitted April 3 until April 8, the second Inpatient Hospital Copayment is waived even though it is a new Quarter because it is within 30 calendar days of the original discharge. • If you are admitted March 2 until March 7, and then readmitted April 30 until May 2, you are responsible for the second Inpatient Hospital Copayment. The second admission occurred more than 30 days from the original discharge and it is a new Quarter. • If you are admitted June 2 until June 7, and then readmitted July 1 until July 4, you are responsible for the second Inpatient Hospital Copayment. Although the second admission occurred less than 30 days from the original discharge, it happened during a new Plan Year.	
Surgical Day Care Copayment	
	$250 Copayment per visit, or $150 Copayment per visit for outpatient eye and gastrointestinal surgical procedures received in an ambulatory surgical center (ASC), up to a maximum of 4 Surgical Day Care Copayments per Member per Plan Year. See the benefit for Surgical Day Care below for details.
Other Copayments	
	See Covered Benefits below for details.

General Cost Sharing Features:	Member Cost Sharing:
Deductibles – Medical	
In-Network Deductible	$500 per Member per Plan Year $1,000 per family per Plan Year
Out-of-Network Deductible	$500 per Member per Plan Year $1,000 per family per Plan Year
The In-Network Deductible for medical care is separate from the Out-of-Network Deductible.	
Coinsurance	
In-Network Coinsurance	20% Coinsurance for durable medical equipment and Skilled Nursing Facility care
Out-of-Network Coinsurance	20% Coinsurance
Out-of-Pocket Maximums	
In-Network Out-of Pocket Maximum includes all In-Network Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year
Out-of-Network Out-of-Pocket Maximum includes all Out-of-Network Member Cost Sharing except: • Copayments • Coinsurance for Skilled Nursing Facility care • Any charges above the Allowed Amount • Any penalty for failure to receive Prior Approval when using Non-Plan Providers	$5,000 per Member per Plan Year $10,000 per family per Plan Year
The In-Network Out-of-Pocket Maximum is separate from the Out-of-Network Out-of-Pocket Maximum.	
Out-of-Network Penalty Payment	
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum.	$500 for medical care $200 for mental health care (including the treatment of substance use disorders)

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. The benefit table below is a summary of the services covered by your Plan. It also indicates your Member Cost Sharing, such as Copayment, Deductible or Coinsurance amounts. More detailed information about Covered Benefits can be found in your Benefit Handbook. 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 "Surgical Day Care."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

You have one set of Covered Benefits under the Plan. If a benefit limit applies (such as a day, visit or dollar limit), HPHC calculates your utilization for that benefit based on the Covered Benefits you have received from both In-Network Plan Providers and Out-of-Network Non-Plan Providers.

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance and Medical Transport		
Emergency ambulance transport, including ground and/or air transportation	In-Network Deductible, then no charge	
Non-emergency medical transport (ground only), including ambulance and wheelchair vans	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	$20 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Chiropractic Care		
– Limited to 20 visits per Plan Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Emergency dental care (received within 3 days of injury) Reduction of fractures and removal of cysts or tumors	Office Visits: $45 Copayment per visit Hospital Inpatient Services: $275 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Please note: The Covered Benefits below are **only** provided when the Member has a serious medical condition that makes it essential that he or she be admitted to a hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.		
– Removal of seven or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants	Hospital Inpatient Services: $275 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Diabetes Equipment and Supplies		
Diabetes equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Blood glucose monitors, insulin pumps and supplies and infusion devices	Deductible, then no charge	Deductible, then no charge
Diabetes equipment including needles and syringes for the administration of insulin are covered by this Plan. Insulin (other than insulin administered with an insulin pump) and other pharmacy supplies are covered under your outpatient prescription drug coverage, which is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs.		
Pharmacy supplies	See your **CVS Caremark Prescription Drug Plan brochure** for cost sharing amounts.	
Dialysis		
Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
Installation of home equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	Deductible, then 20% Coinsurance
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	$275 Copayment per admission, then In-Network Deductible **Please Note:** Emergency admission to a mental health facility is subject to a $275 Copayment per admission.	
Emergency Room Care		
	$100 Copayment per visit, then the In-Network Deductible	
This $100 Copayment is waived if the patient is (1) transferred to either Observation Services or Surgical Day Care or (2) admitted directly to the hospital from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgical Day Care including Scopic Procedures" for the Member Cost Sharing that applies to these benefits.		
Gender Affirming Services		
	Hospital Inpatient Services: $275 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hearing Aids		
Hearing Aids (for Members up to the age of 22) – $2,000 per hearing aid every 24 months for each hearing impaired ear	No charge	
Hearing aids - (for Member ages 22 and older) – $1,700 per hearing aid every 24 months for each hearing impaired ear	No charge	
Home Health Care Services		
	Deductible, then no charge No cost sharing applies to durable medical equipment, physical therapy, occupational therapy or speech therapy received as part of authorized home health care.	Deductible, then 20% Coinsurance
Hospice – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	$275 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Inpatient maternity care	$275 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Non-routine inpatient services for the newborn	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled Nursing Facility limited to 100 days per Plan Year	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
– Advanced reproductive technologies are limited to 5 cycles per lifetime	Specialist Copayment: $45 per visit	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then no charge	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiology	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$100 Copayment per scan, then Deductible. There is a maximum of one Copayment per Member per day.	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (Continued)		
Other diagnostic services	Deductible, then no charge	Deductible, then 20% Coinsurance
Low Protein Foods		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
Non-routine outpatient prenatal and postpartum care	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. Your outpatient prescription drug coverage is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	$275 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate care services	No charge	Deductible, then 20% Coinsurance
Annual mental health wellness examination performed by a licensed mental health professional **Please Note:** Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care	No charge	Deductible, then 20% Coinsurance
Outpatient services	Group therapy – $10 Copayment per visit Individual therapy – $20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient detoxification	No charge	Deductible, then 20% Coinsurance
Acupuncture treatment for detoxification	$20 Copayment per visit	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
Outpatient medication management	$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No charge	Deductible, then 20% Coinsurance
Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of your Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section J. Utilization Review Procedures of your Handbook.		
Observation Services		
	$100 Copayment, then Deductible	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Prescription Drug Coverage		
Your outpatient prescription drug coverage is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs. Regardless of whether the CVS Caremark brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the CVS Caremark Prescription Drug Plan brochure.		
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
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 our website at **www.harvardpilgrim.org/GIC**. 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, sickness and injury care Allergy tests and treatments Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per Plan Year)	PCP Copayment: $20 per visit Specialist Copayment: $45 per visit	Deductible, then 20% Coinsurance
Administration of allergy injections Diagnostic screening and tests (including EKGs)	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests		
Preventive care services, including all FDA approved generic contraceptive devices Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a list of covered preventive services, please see the Preventive Services Notice on our website at: **www.harvardpilgrim.org/GIC**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1-844-442-7324**.	No charge	Deductible, then 20% Coinsurance
Under applicable 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 and tests go to HPHC's website at **www.harvardpilgrim.org/GIC**. You may also get a copy by calling the Member Services department at **1-844-442-7324**. HPHC will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		
Prosthetics and Orthotics		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Reconstructive Surgery		
	$275 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	$20 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Speech-language and hearing services	$20 Copayment per visit	Deductible, then 20% Coinsurance
Occupational therapy limited to 30 visits per Plan Year Physical therapy limited to 30 visits per Plan Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Smoking Cessation		
Smoking Cessation (please see your Benefit Handbook for details on your coverage)	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Surgical Day Care including Scopic Procedures		
Outpatient surgery, including outpatient scopic procedures (except for eye and gastrointestinal procedures)	$250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Outpatient eye surgical procedures and gastrointestinal surgical procedures, including but not limited to colonoscopy, endoscopy and sigmoidoscopy		
– In an ambulatory surgical center (ASC)	$150 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
– In a hospital	$250 Copayment per visit, then Deductible	
	There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.	
For a list of covered ambulatory surgical centers (ASC) go to our website at **www.harvardpilgrim.org/GIC**, go to your Harvard Pilgrim Access America Plan "Provider Directory", click "Hospitals, Urgent Care, Labs and more" under Quicklinks on the right side of the page, then select "Ambulatory Surgical Center".		
Telemedicine Virtual Visit Services		
Outpatient telemedicine virtual visit services: - Medical services	PCP Copayment: $20 per visit Specialist Copayment: $45 per visit	Deductible, then 20% Coinsurance
- Mental health and substance use disorder services	No charge for the first 3 visits per Member per Plan Year, then $10 Copayment per visit for all visits after the first 3	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital - Inpatient Services."		
Temporomandibular Joint Dysfunction Services		
	Specialist Copayment: $45 per visit	Deductible, then 20% Coinsurance
No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).		
Urgent Care Services		
Doctor On Demand	$20 Copayment per visit	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For Doctor On Demand go to our website at **www.harvardpilgrim.org/GIC**, go to your Harvard Pilgrim Access America Plan "Provider Directory", click "Hospitals, Urgent Care, Labs and more" under Quicklinks on the right side of the page, then select "Doctor On Demand Urgent Care".		
Convenience care clinic	$20 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center (including hospital urgent care center)	$20 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Urgent Care Services (Continued)		
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."		
Vision Services		
Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: $20 per visit Ophthalmologist Copayment: – Specialist Copayment: $45 per visit	Deductible, then 20% Coinsurance
Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details and limits on your coverage)	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Sterilization		
	Office visits: Specialist Copayment: $45 per visit Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy (abortion)		
	No charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses		
When needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia, or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury	No charge	Deductible, then 20% Coinsurance

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-844-442-7324 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-844-442-7324 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-844-442-7324 (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 1-844-442-7324（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-844-442-7324 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-442-7324 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم أللُغةِ **العربية** ، خَدَمات ألمُساعَدة أللُغَوية مُتَوفرة لك مَجانا.ً **إتصل على1-844-442-7324** (TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-844-442-7324 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-442-7324 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-442-7324 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-442-7324 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-844-442-7324 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-442-7324 (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. 1-844-442-7324 (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. 1-844-442-7324 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-442-7324 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-442-7324 (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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