

## The Harvard Pilgrim Best Buy ChoiceNet<sup>SM</sup> HMO

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** 07/01/2019 — 06/30/2020

**Coverage for:** Individual + Family | **Plan Type:** HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <http://www.harvardpilgrim.org/LGsampleEOC>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **underlined** terms see the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-333-4742 to request a copy.


| Important Questions   | Answers  | Why this matters  |
|---|--|---|
| What is the overall <u>deductible</u> ?                             | <b>Tier 1 Providers:</b> \$300 member / \$900 family<br><b>Tier 2 Providers:</b> \$300 member / \$900 family<br><b>Tier 3 Providers:</b> \$300 member / \$900 family<br>Benefits are administered on a Plan Year basis.  | Generally you must pay all the costs up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , <u>provider</u> office visits, prescription drugs, <u>Rehabilitation</u> services, <u>Habilitation</u> services and routine eye exams are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But, a <u>copayment</u> or <u>coinsurance</u> may apply.  |
| Are there other <u>deductibles</u> for specific services?           | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$2,000 member / \$4,000 family  | The <u>out-of-pocket limit</u> is the most you could pay in a year of covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.   |



#### Clarification on SBC format

As of April 1, 2017 the federal government has issued a new format for the *Summary of Benefits and Coverage* (SBC) document. One of the most significant changes to the format is the way deductibles are referenced in the cost-sharing chart. The cost-sharing chart shows copayments and coinsurance **after** the deductible has been met.

- A statement appears at the top of the chart noting that all copayments and coinsurance are **after the deductible has been met**, if a deductible applies (see example below). Please note that this wording appears only at the top of the chart.

|   |  |
|---|--|
|  | All <u>copayments</u> and <u>coinsurance</u> cost shown in this chart after your <u>deductible</u> has been met, if a <u>deductible</u> applies. |
|---|--|

- If the deductible does not apply to a benefit, the phrase "deductible does not apply" appears in the chart.
- If the "What You Will Pay" column, indicates "no charge," this means no charge **after** the deductible has been met.


| Common Medical Event | Services You May Need               | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information |
|----------------------|-------------------------------------|---|--|--|
|                      |                                     | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| If you have a test   | Diagnostic test (x-ray, blood work) | X-rays:<br>No charge<br>Laboratory: Select Providers:<br>No charge; <u>deductible</u> does not apply.<br>Other Plan Providers:<br>No charge | Not covered  | None   |
|                      | Imaging (CT/PET scans, MRIs)        | No charge   | Not covered  | Cost sharing may vary for certain imaging services.    |

We encourage readers to reference *Schedule of Benefits* documents for cost-sharing details. The *Schedule of Benefits* is the contract between a member and Harvard Pilgrim Health Care and is the more complete document.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.



**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

| Important Questions   |   | Answers  | Why this matters   |  |
|---|---|--|--|--|
| What is not included in the <u>out-of-pocket limit</u> ?                          |   | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |  |
| Will you pay less if you use a <u>network provider</u> ?                          |   | Yes. See <a href="https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx">https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx</a> or call 1-888-333-4742 for a list of <u>preferred providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance-billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |  |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?                        |   | Yes, some exceptions apply.  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .   |  |
|  | All <u>copayment</u> and <u>coinsurance</u> cost shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. |  |  |  |
| Common Medical Event  | Services You May Need   | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information |
|   |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)   |  |
| If you visit a health care <u>provider's</u> office or clinic                     | Primary care visit to treat an injury or illness  | Tier 1 Primary Care: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 2 Primary Care: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 3 Primary Care: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered  | None   |
|   | <u>Specialist</u> visit   | Tier 1 Specialty & Hospital Based: \$30 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 2 Specialty & Hospital Based: \$60 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 3 Specialty & Hospital Based: \$90 <u>copay</u> / visit; <u>deductible</u> does not apply | Not covered  | None   |



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| Common Medical Event  | Services You May Need                           | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
|   | <u>Preventive care/ screening/ immunization</u> | No charge; <u>deductible</u> does not apply  | Not covered  | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)      | <b>Non-Hospital Based:</b> No charge<br><b>Physician &amp; Hospital Based: Tier 1 Providers:</b> No charge<br><b>Tier 2 Providers:</b> No charge<br><b>Tier 3 Providers:</b> No charge   | Not covered  | None  |
|   | Imaging (CT/PET scans, MRIs)                    | <b>Non-Hospital Based:</b> \$100 <u>copay</u> / procedure<br><b>Physician &amp; Hospital Based: Tier 1 Providers:</b> \$100 <u>copay</u> / procedure<br><b>Tier 2 Providers:</b> \$100 <u>copay</u> / procedure<br><b>Tier 3 Providers:</b> \$100 <u>copay</u> / procedure | Not covered  | None  |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.harvardpilgrim.org/2019Premium3T">www.harvardpilgrim.org/2019Premium3T</a> . | Generic drugs                                   | <b>30-Day Retail Tier 1:</b> \$10 <u>copay</u> / prescription; <u>deductible</u> does not apply<br><b>90-Day Mail Order Tier 1:</b> \$25 <u>copay</u> / prescription; <u>deductible</u> does not apply   |  | None  |
|   | Preferred brand drugs                           | <b>30-Day Retail Tier 2:</b> \$30 <u>copay</u> / prescription; <u>deductible</u> does not apply<br><b>90-Day Mail Order Tier 2:</b> \$75 <u>copay</u> / prescription; <u>deductible</u> does not apply   |  | Some generic drugs are in this tier.  |
|   | Non-preferred brand drugs                       | <b>30-Day Retail Tier 3:</b> \$65 <u>copay</u> / prescription; <u>deductible</u> does not apply  |  | Same as above.  |

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| Common Medical Event                    | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information                                  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
|   |  | <b>90-Day Mail Order Tier 3:</b> \$165 <u>copay</u> / prescription; <u>deductible</u> does not apply  |  |   |
|   | <u>Specialty drugs</u>                         | All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3  |  | Some drugs must be obtained through a Specialty Pharmacy.                               |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | <b>Tier 1 Providers:</b> \$250 <u>copay</u> / visit<br><b>Tier 2 Providers:</b> \$250 <u>copay</u> / visit<br><b>Tier 3 Providers:</b> \$250 <u>copay</u> / visit   | Not covered  | None  |
|   | Physician/surgeon fees                         | <b>Tier 1 Providers:</b> No charge<br><b>Tier 2 Providers:</b> No charge<br><b>Tier 3 Providers:</b> No charge  | Not covered  |   |
| If you need immediate medical attention | <u>Emergency room care</u>                     | \$100 <u>copay</u> / visit  |  | None  |
|   | <u>Emergency medical transportation</u>        | No charge   |  | None  |
|   | <u>Urgent care</u>                             | <b>Convenience care clinic:</b> Tier 1: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 2: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 3: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br><b>Urgent care center:</b> Tier 1: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 2: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 3: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br><b>Hospital urgent care center:</b> Tier 1: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Tier 2: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply | <b>Convenience care clinic:</b> Not covered<br><b>Urgent care center:</b> Not covered<br><b>Hospital urgent care center:</b> Same As Participating <u>Provider</u> | Services with non-participating providers are only covered outside of the service area. |



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| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|--|---|
|  |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
|  |   | <b>Tier 3:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply  |  |   |
| If you have a hospital stay  | Facility fee (e.g., hospital room)        | <b>Tier 1 Providers:</b> \$250 <u>copay</u> / admit<br><b>Tier 2 Providers:</b> \$500 <u>copay</u> / admit<br><b>Tier 3 Providers:</b> \$1,500 <u>copay</u> / admit   | Not covered  | None  |
|  | Physician/surgeon fee                     | <b>Tier 1 Providers:</b> No charge<br><b>Tier 2 Providers:</b> No charge<br><b>Tier 3 Providers:</b> No charge  | Not covered  |   |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services                       | <b>Tier 1 Primary Care:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered  | None  |
|  | Inpatient services                        | \$250 <u>copay</u> / admit  | Not covered  |   |
| If you are pregnant  | Office visits                             | <b>Tier 1 Primary Care:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br><b>Tier 2 Primary Care:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply<br><b>Tier 3 Primary Care:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|  | Childbirth/delivery professional services | <b>Tier 1 Providers:</b> No charge<br><b>Tier 2 Providers:</b> No charge<br><b>Tier 3 Providers:</b> No charge  | Not covered  |   |
|  | Childbirth/delivery facility services     | <b>Tier 1 Providers:</b> \$250 <u>copay</u> / admit<br><b>Tier 2 Providers:</b> \$500 <u>copay</u> / admit<br><b>Tier 3 Providers:</b> \$1,500 <u>copay</u> / admit   | Not covered  |   |



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| Common Medical Event  | Services You May Need            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|--|--|
|   |                                  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need help recovering or have other special health needs  | <u>Home health care</u>          | No charge   | Not covered  | None   |
|   | <u>Rehabilitation services</u>   | \$20 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered  | Occupational Therapy – 30 visits/ Plan Year  |
|   | <u>Habilitation services</u>     | \$20 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered  | Physical Therapy – 30 visits/ Plan Year  |
|   | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>  | Not covered  | – 100 days/ Plan Year  |
|   | <u>Durable medical equipment</u> | No charge   | Not covered  | None   |
|   | <u>Hospice services</u>          | No charge   | Not covered  | For inpatient services, see “If you have a hospital stay”.   |
| If your child needs dental or eye care  | Children’s eye exam              | No charge; <u>deductible</u> does not apply   | Not covered  | – 1 exam/ 2 Plan Years   |
|   | Children’s glasses               | Not covered   |  | None   |
|   | Children’s dental check-up       | <b>Tier 1 Primary Care:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered  | – 2 exams/ Plan Year up to age 13  |
| <b>Excluded Services &amp; Other Covered Services:</b>  |                                  |   |  |  |
| <b>Services Your <u>Plan</u> Does NOT Cover (This isn’t a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u>.)</b>         |                                  |   |  |  |
| <ul style="list-style-type: none"><li>Acupuncture</li><li>Long-Term (Custodial) Care</li><li>Most Cosmetic Surgery</li></ul>  |                                  | <ul style="list-style-type: none"><li>Non-emergency care when traveling outside the U.S.</li><li>Private-duty nursing</li><li>Most Dental Care (Adult)</li></ul>      |  | <ul style="list-style-type: none"><li>Routine foot care</li><li>Services that are not Medically Necessary</li><li>Weight Loss Programs</li></ul> |
| <b>Other Covered Services (This isn’t a complete list. Check your policy or <u>plan</u> document for other covered services and your costs for these services.)</b> |                                  |   |  |  |
| <ul style="list-style-type: none"><li>Bariatric surgery</li></ul>   |                                  | <ul style="list-style-type: none"><li>Chiropractic Care - 20 visits/ Plan Year</li><li>Hearing Aids - \$1,500/ hearing aid every 2 Plan Years/ impaired ear</li></ul> |  | <ul style="list-style-type: none"><li>Infertility Treatment</li><li>Routine eye care (Adult) - 1 exam/ 2 Plan Years</li></ul>                    |



## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member  
Services Department  
Harvard Pilgrim Health Care, Inc.  
1600 Crown Colony Drive  
Quincy, MA 02169  
**Telephone: 1-888-333-4742**  
**Fax: 1-617-509-3085**

Department of Labor's Employee  
Benefits Security Administration  
**1-866-444-3272**  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Health Care for All  
30 Winter Street, Suite 1004  
Boston, MA 02108  
**1-800-272-4232**  
<http://www.hcfama.org/helpline>

Massachusetts Division of  
Insurance  
1000 Washington Street, Suite 810  
Boston, MA 02118-6200  
**1-617-521-7794**

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

————— To see examples of how this plan might cover costs for a sample medical situation, see the next page. —————



## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

### About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductible](#), [copayment](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)   |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)  |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)   |                |
|---|-----------------|---|----------------|---|----------------|
| ■ The plan's overall deductible   | \$300           | ■ The plan's overall deductible   | \$300          | ■ The plan's overall deductible   | \$300          |
| ■ Specialist <a href="#">copayment</a>  | \$20            | ■ Specialist <a href="#">copayment</a>  | \$20           | ■ Specialist <a href="#">copayment</a>  | \$20           |
| ■ Hospital (facility) <a href="#">copayment</a>   | \$250           | ■ Hospital (facility) <a href="#">copayment</a>   | \$250          | ■ Hospital (facility) <a href="#">copayment</a>   | \$250          |
| ■ Other <a href="#">copayment</a>   | \$0             | ■ Other <a href="#">copayment</a>   | \$0            | ■ Other <a href="#">copayment</a>   | \$0            |
| This EXAMPLE event includes services like:<br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                 | This EXAMPLE event includes services like:<br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                | This EXAMPLE event includes services like:<br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>   | <b>\$12,731</b> | <b>Total Example Cost</b>   | <b>\$7,389</b> | <b>Total Example Cost</b>   | <b>\$1,925</b> |
| In this example, Peg would pay:   |                 | In this example, Joe would pay:   |                | In this example, Mia would pay:   |                |
| <i>Cost Sharing</i>   |                 | <i>Cost Sharing</i>   |                | <i>Cost Sharing</i>   |                |
| <a href="#">Deductibles</a>   | \$300           | <a href="#">Deductibles</a>   | \$130          | <a href="#">Deductibles</a>   | \$300          |
| <a href="#">Copayments</a>  | \$330           | <a href="#">Copayments</a>  | \$1,660        | <a href="#">Copayments</a>  | \$120          |
| <a href="#">Coinsurance</a>   | \$0             | <a href="#">Coinsurance</a>   | \$0            | <a href="#">Coinsurance</a>   | \$0            |
| <i>What isn't covered</i>   |                 | <i>What isn't covered</i>   |                | <i>What isn't covered</i>   |                |
| Limits or exclusions  | \$0             | Limits or exclusions  | \$30           | Limits or exclusions  | \$0            |
| <b>The total Peg would pay is</b>   | <b>\$630</b>    | <b>The total Joe would pay is</b>   | <b>\$1,820</b> | <b>The total Mia would pay is</b>   | <b>\$420</b>   |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## 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).

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

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**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).

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**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)。

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**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).

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

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**العربية (Arabic)**

إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742

(TTY: 711)

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

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

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**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).

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

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

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

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**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)

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**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)

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

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**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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