# Schedule of Benefits

## THE HARVARD PILGRIM CHOICENET℠ BEST BUY PPO MASSACHUSETTS

**Please Note:** This plan includes a tiered provider network called the "ChoiceNet" Network. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a Provider's benefit tier annually on January 1. Please consult the HPHC ChoiceNet Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine the tier of Providers in the ChoiceNet Network.

This Schedule of Benefits states any Benefit Limits and 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. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

### 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.

**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.

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.

### Out-of-Network Notification and Prior Approval

Notification and Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, please refer our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. To provide Notification or obtain Prior Approval please call **1–800–708–4414** for medical services or call **1-888-777-4742** for mental health or substance abuse services. More information about Notification and Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

### 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** or by calling **1-888-888-4742 ext. 38723**.

### Tiered Providers — In-Network

In-Network acute hospitals, Primary Care Providers (PCPs), and medical specialists are placed into one of three benefit levels or "tiers" based on national measures of cost efficiency and relative quality. Member Cost Sharing for these providers depends upon the tier in which a provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Please see your Benefit Handbook for more information on how hospitals and physicians are tiered under the Plan. Only acute care hospitals, Primary Care Providers (PCPs), and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 1.

Tiering also does not apply to physicians and hospitals that specialize in the provision of mental health care. These include psychiatrists and psychiatric hospitals.

You can lower your out-of-pocket cost by selecting In-Network physicians and hospitals in the lower cost tiers. The tables set forth below list the Member Cost Sharing for each type of tiered service. The ChoiceNet Provider Directory lists all Plan Providers and their tier. You can access the Provider Directory at **www.harvardpilgrim.org.** You may also obtain a paper copy of the directory, free of charge, by calling our Member Services Department at **1–888–333–4742**.

**Please Note:** When you choose a provider, it is important to consider the tier of the hospital that your provider uses. For example, a Tier 1 doctor may admit patients to a Tier 2 or to a Tier 3 hospital.

## Deductibles

A Deductible is a dollar amount a Member must pay each Plan Year before any benefits subject to the Deductible are payable by the Plan. Any eligible expenses you incur toward the Deductible in a Plan Year apply to **both** your Plan's In-Network and Out-of-Network Deductibles. Your Plan has an individual Deductible. If you have family coverage you also have a separate family deductible. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Your Plan's Deductibles are listed in the tables below.

For **In-Network Coverage**, the Plan has separate limits on the Deductible that apply to each tier. If you only use services in Tier 1 during the Plan Year, you will only be responsible for the Tier 1 Deductible in that Plan Year. If you only use services in Tiers 1 and 2 in a Plan Year, you will only be responsible for the Tier 2 Deductible amount in that Plan Year. Even if you use Tier 3 services, your Deductible for In-Network Services, is limited to the Tier 3 Deductible stated in the tables below.

For **Out-of-Network Coverage**, the Plan has a separate Deductible that applies to Out-of-Network Services. The Out-of Network Deductible is generally higher than the Tier 3 In-Network Deductible. Please see the tables below for your Out-of-Network Deductible.

**Please Note:** Any Deductible you incur for Covered Benefits under the Plan applies to both your In-Network and Out-of-Network Deductibles for the remainder of the Plan Year. For example, if you incurred $200 in Deductible charges for care by a Tier 1 physician in January, for the reminder of the Plan Year that $200 amount would apply toward any Deductible under the Plan. If you used Out-of-Network services later in the Plan Year, the $200 would count toward the Out-of-Network Deductible.

## Copayment Levels

There are two types of In-Network office visit Copayments that apply to your plan: a lower Copayment, known as the "Primary Care Copayment," and a higher Copayment, known as the "Specialty and Hospital Based Care Copayment."

The Primary Care Copayment applies to covered outpatient professional services, other than services received at a professional office operated by a hospital 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.

The Specialty and Hospital Based Care Copayment applies to most outpatient specialty care.

If a provider is categorized at both Copayment levels, the Primary Care Copayment applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for the Primary Care Copayment.

## 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 Member Services Department at **1-888-333-4742**. 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 doctor'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."

| General Cost Sharing Features | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing: | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Coinsurance and Copayments** | | | | |
| | See the benefits table below | | | |
| **Deductibles** | | | | |
| Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.The following Deductibles apply to all services except where specifically noted below. The Deductible amount listed in each tier is the maximum you would pay for all services during the Plan Year in that tier or a lower tier. | $1,000 per Member per Plan Year<br>$2,000 per family per Plan Year | $1,000 per Member per Plan Year<br>$2,000 per family per Plan Year | $1,000 per Member per Plan Year<br>$2,000 per family per Plan Year | $1,000 per Member per Plan Year<br>$2,000 per family per Plan Year |
| **Out-of-Pocket Maximum** | | | | |
| Includes all In-Network and Out-of-Network Member Cost Sharing except:<br>– Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum<br>– Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers. | $4,000 per Member per Plan Year<br>$8,000 per family per Plan Year | | | |
| **Out-of-Network Penalty Payment** | | | | |
| Does not count toward the Deductible or Out-of-Pocket Maximum. | $500 | | | |
| **Deductible Rollover** | | | | |
| None | | | | |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Acupuncture Treatment for Injury or Illness** | | | | |
| | Not covered | | | Not covered |
| **Ambulance Transport** | | | | |
| Emergency ambulance transport | Tier 1 Deductible, then no charge | | | Same as In-Network |
| Non-emergency ambulance transport | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Autism Spectrum Disorders Treatment** | | | | |
| Applied behavior analysis | Not covered | | | Not covered |
| **Chemotherapy and Radiation Therapy** | | | | |
| | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | 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. | | | | |
| Extraction of teeth impacted in bone | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." | | | Deductible, then 20% Coinsurance |
| Pediatric dental care for children up to the age of 13 – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays. | Tier 1 Primary Care Copayment: $20 per visit | | | Deductible, then 20% Coinsurance |
| **Dialysis** | | | | |
| Dialysis services | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Installation of home equipment is covered up to $300 in a Member's lifetime. | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Durable Medical Equipment** | | | | |
| Durable medical equipment | 20% Coinsurance | | | Deductible, then 20% Coinsurance |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | No charge | | | Same as In-Network |
| Oxygen and respiratory equipment | No charge | | | No charge |
| **Early Intervention Services** | | | | |
| | No charge | | | No charge |
| The Plan does not cover the Family Participation Fee required by the Massachusetts Department of Public Health | | | | |
| **Emergency Admission** | | | | |
| | Tier 1 Deductible, then $275 Copayment per admission | | | Same as In-Network |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Emergency Room Care** | | | | |
| | Tier 1 Deductible, then $100 Copayment per visit | | | Same as In-Network |
| This Copayment is waived if admitted to the hospital directly from the emergency room. | | | | |
| **Hearing Aids** | | | | |
| | Not covered | | | Not covered |
| **Home Health Care** | | | | |
| | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | | | | |
| **Hospice – Outpatient** | | | | |
| | Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." | | | Deductible, then 20% Coinsurance |
| **Hospital – Inpatient Services** | | | | |
| Acute hospital care | Deductible, then $275 Copayment per admission | Deductible, then $500 Copayment per admission | Deductible, then $1,250 Copayment per admission | Deductible, then 20% Coinsurance |
| Inpatient maternity care | Deductible, then $275 Copayment per admission | Deductible, then $500 Copayment per admission | Deductible, then $1,250 Copayment per admission | Deductible, then 20% Coinsurance |
| Inpatient routine nursery care | No charge | | | Deductible, then 20% Coinsurance |
| Inpatient rehabilitation – limited to 60 days per Plan Year | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Skilled nursing facility – limited to 100 days per Plan Year | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Hypodermic Syringes and Needles** | | | | |
| | Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card.<br>If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies. | | | |
| For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"** or contact the Member Services Department at **1–888–333–4742**. | | | | |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Infertility Services and Treatments (see the Benefit Handbook for details)** | | | | |
| | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, 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 inpatient hospital care, see "Hospital – Inpatient Services." | | | Deductible, then 20% Coinsurance |
| **Laboratory and Radiology Services** | | | | |
| Non–hospital based laboratory and x-rays | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Hospital based laboratory and x-rays | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Non–hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Low Protein Foods** | | | | |
| – Limited to $5,000 per Plan Year | Tier 1 Deductible, then no charge | | | Deductible, then no charge |
| **Maternity Care - Outpatient** | | | | |
| Routine outpatient prenatal and postpartum care | No charge | | | Deductible, then 20% Coinsurance |
| 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 service is listed under "Laboratory and Radiology Services." | | | | |
| **Medical Drugs (drugs that cannot be self-administered)** | | | | |
| Medical drugs received in a doctor's office or other outpatient facility | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Medical drugs received in the home | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| 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. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits. | | | | |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Medical Formulas** | | | | |
| | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Mental Health Care (Including the Treatment of Substance Abuse Disorders)** | | | | |
| Inpatient Services | Tier 1 Deductible, then $275 Copayment per admission | | | Deductible, then 20% Coinsurance |
| Intermediate services<br>– Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization<br>– Intensive outpatient programs, partial hospitalization and day treatment programs | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Outpatient group therapy | $10 Copayment per visit | | | Deductible, then 20% Coinsurance |
| Outpatient treatment, including individual therapy, outpatient detoxification and medication management | Tier 1 Primary Care Copayment: $10 per visit | | | Deductible, then 20% Coinsurance |
| Outpatient methadone maintenance | Not covered | | | Not covered |
| Outpatient psychological testing and neuropsychological assessment<br>– Performed by a licensed mental health professional | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| – Performed by a neurologist or other medical specialist | See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits." | | | Deductible, then 20% Coinsurance |
| **Ostomy Supplies** | | | | |
| | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)** | | | | |
| Routine examinations for preventive care, including immunizations | No charge | | | Deductible, then 20% Coinsurance |
| Not all In-Network 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 **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list. | | | | |
| Consultations, evaluations, sickness and injury care | Primary Care Copayment: $10 per visit Specialty and Hospital Based Care Copayment: $20 per visit | Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $40 per visit | Primary Care Copayment: $40 per visit Specialty and Hospital Based Care Copayment: $60 per visit | Deductible, then 20% Coinsurance |
| Office based treatments and procedures, including, but not limited to: administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, neurological testing, non-routine foot care, office surgical procedures, and pregnancy testing | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Administration of allergy injections | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Preventive Services and Tests** | | | | |
| | No charge | | | Deductible, then 20% Coinsurance |
| Under federal 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 **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance. | | | | |
| The following additional preventive services and tests: fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, and routine hemoglobin tests | No charge | | | Deductible, then 20% Coinsurance |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Prosthetic Devices** | | | | |
| | 20% Coinsurance | | | Deductible, then 20% Coinsurance |
| **Rehabilitation and Habilitation Services - Outpatient** | | | | |
| Cardiac rehabilitation | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Pulmonary rehabilitation therapy | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Speech-language and hearing services | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| Occupational therapy – limited to 60 visits per Plan Year<br>Physical therapy – limited to 60 visits per Plan Year | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | | | | |
| Endoscopy and sigmoidoscopy | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, 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 "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services." | | | Deductible, then 20% Coinsurance |
| Colonoscopy | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Spinal Manipulative Therapy (including care by a chiropractor)** | | | | |
| | Not covered | | | Not covered |
| **Surgery – Outpatient** | | | | |
| | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Telemedicine** | | | | |
| Outpatient and inpatient telemedicine services | Your Member Cost Sharing will depend upon the types of services 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." | | | |
| **Urgent Care Services** | | | | |
| Convenience care clinic | Primary Care Copayment: $20 per visit | Primary Care Copayment: $20 per visit | Primary Care Copayment: $20 per visit | Deductible, then 20% Coinsurance |

| Benefit | In-Network Tier 1 Member Cost Sharing | In-Network Tier 2 Member Cost Sharing | In-Network Tier 3 Member Cost Sharing | Out-of-Network Member Cost Sharing |
|---|---|---|---|---|
| **Urgent Care Services (Continued)** | | | | |
| Urgent care clinic (including hospital urgent care clinic) | $20 Copayment per visit | $20 Copayment per visit | $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services." | | | | |
| **Vision Services** | | | | |
| Routine eye examinations – limited to 1 exam per Plan Year | Primary Care Copayment: $20 per visit | Primary Care Copayment: $20 per visit | Primary Care Copayment: $20 per visit | Deductible, then 20% Coinsurance |
| Vision hardware for special conditions | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Voluntary Sterilization in a Physician's Office** | | | | |
| | Tier 1 Deductible, then no charge | | | Deductible, then 20% Coinsurance |
| **Voluntary Termination of Pregnancy** | | | | |
| | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, 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" | | | Deductible, then 20% Coinsurance |
| **Wigs and Scalp Hair Prostheses as required by law** | | | | |
| Limited to $350 per Plan Year (see the Benefit Handbook for details) | 20% Coinsurance | | | 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 1-888-333-4742 (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 quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí 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 مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

**ខ្មែរ (Cambodian)** ប្រសូមជូនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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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