


## The Harvard Pilgrim Independence<sup>SM</sup> POS

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

**Coverage Period:** 07/01/2021 — 06/30/2022

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

	<p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <a href="#">plan</a>. The SBC shows you how you and the <a href="#">plan</a> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <a href="#">plan</a> (called the premium) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>. For general definitions of common terms, such as <a href="#">allowed amount</a>, <a href="#">balance billing</a>, <a href="#">coinsurance</a>, <a href="#">copayment</a>, <a href="#">deductible</a>, <a href="#">provider</a>, or other <b>underlined</b> terms, see the Glossary. You can view the Glossary at <a href="http://www.harvardpilgrim.org/fhcr">www.harvardpilgrim.org/fhcr</a> or call 1-888-333-4742 to request a copy.</p>	
Important Questions	Answers	Why this matters
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>In-Network:</b> \$500 member / \$1,000 family <b>Out-of-Network:</b> \$500 member / \$1,000 family</p>	<p>Generally you must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. The following <b>In-Network</b> services: <a href="#">preventive care</a>, <a href="#">provider</a> office visits, mental health, <a href="#">rehabilitation services</a>, and <a href="#">habilitation services</a> are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. <b>Prescription Drug Deductible:</b> \$100 member / \$200 family There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>In-Network:</b> \$5,000 member / \$10,000 family <b>Out-of-Network:</b> \$5,000 member / \$10,000 family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year of covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>

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Important Questions	Answers	Why this matters
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, penalties for failure to obtain <u>preauthorization</u> for services and health care this plan 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.harvardpilgrim.org/public/find-a-provider">https://www.harvardpilgrim.org/public/find-a-provider</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> .



Copayments and coinsurance cost shown in this chart are both before and after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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	Level 1: \$10 <u>copay</u> / visit; <u>deductible</u> does not apply Level 2: \$20 <u>copay</u> / visit; <u>deductible</u> does not apply Level 3: \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	Level 1: \$30 <u>copay</u> / visit; <u>deductible</u> does not apply Level 2: \$60 <u>copay</u> / visit; <u>deductible</u> does not apply Level 3: \$75 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>X-rays:</b> No charge <b>Laboratory:</b> No charge	<b>X-rays:</b> 20% <a href="#">coinsurance</a> <b>Laboratory:</b> 20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> / scan	20% <a href="#">coinsurance</a>	Participating Providers limited to a maximum of 1 <a href="#">copay</a> / Member/ day. <b>Out-of-Network <a href="#">preauthorization</a></b> required. \$500 penalty if not obtained
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com/gicrx">www.express-scripts.com/gicrx</a> .	Generic drugs	<b>Retail:</b> \$10 <a href="#">copay</a> after <a href="#">deductible</a> <b>Maintenance 90/Mail Order:</b> \$25 <a href="#">copay</a> after <a href="#">deductible</a>		Prescription drug coverage is administered by Express Scripts. For additional information, visit <a href="http://www.express-scripts.com/gicrx">www.express-scripts.com/gicrx</a> or call Customer Service at 1-855-283-7679 (TTY 711).  Retail cost share is up to a 30-day supply; mail order cost share is up to a 90-day supply. Some drugs require prior authorization. Some drugs are subject to quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Preferred brand drugs	<b>Retail:</b> \$30 <a href="#">copay</a> after <a href="#">deductible</a> <b>Maintenance 90/Mail Order:</b> \$75 <a href="#">copay</a> after <a href="#">deductible</a>		
	Non-preferred brand drugs	<b>Retail:</b> \$65 <a href="#">copay</a> after <a href="#">deductible</a> <b>Maintenance 90/Mail Order:</b> \$165 <a href="#">copay</a> after <a href="#">deductible</a>		
	<a href="#">Specialty drugs</a>	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy		

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> / visit	20% <u>coinsurance</u>	4 Surgical Day Care <u>Copays</u> / member/ year. <b>Out-of-Network <u>preauthorization</u></b> required. \$500 penalty if not obtained
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> / visit		<b>Copay</b> waived if admitted
	<u>Emergency medical transportation</u>	No charge		None
	<u>Urgent care</u>	<b>Convenience care clinic:</b> \$10 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Urgent care center:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Hospital urgent care center:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply	<b>Convenience care clinic:</b> 20% <u>coinsurance</u> <b>Urgent care center:</b> 20% <u>coinsurance</u> <b>Hospital urgent care center:</b> 20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<b>Tier 1:</b> \$275 <u>copay</u> / admit <b>Tier 2:</b> \$500 <u>copay</u> / admit <b>Tier 3:</b> \$1,500 <u>copay</u> / admit	20% <u>coinsurance</u>	1 Medical or Mental Health/Substance Abuse Hospital Inpatient <u>Copay</u> / Member each Quarter. <b>Out-of-Network <u>preauthorization</u></b> required. \$500 penalty if not obtained
	Physician/surgeon fee	No charge	20% <u>coinsurance</u>	

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$10 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	\$0 <u>copay</u> for first <b>three</b> Mental Health, Behavioral Health/Substance Abuse telehealth visits. <b>Out-of-Network <u>preauthorization</u></b> required. \$200 penalty if not obtained
	Inpatient services	\$275 <u>copay</u> / admit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	1 Medical or Mental Health/Substance Abuse Hospital Inpatient <u>Copay</u> / Member each Quarter. <b>Out-of-Network <u>preauthorization</u></b> required. \$200 penalty if not obtained
If you are pregnant	Office visits	<b>Level 1:</b> \$10 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Level 2:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Level 3:</b> \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . 1 Medical or Mental Health/Substance Abuse Hospital Inpatient <u>Copay</u> / Member each Quarter.
	Childbirth/delivery facility services	<b>Tier 1:</b> \$275 <u>copay</u> / admit <b>Tier 2:</b> \$500 <u>copay</u> / admit <b>Tier 3:</b> \$1,500 <u>copay</u> / admit	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	<b>Physical Therapy:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply	<b>Physical Therapy:</b> 20% <u>coinsurance</u>	Physical & Occupational Therapy - 90 consecutive days/ illness or injury <b>Out-of-Network <u>preauthorization</u></b> required. \$500 penalty if not obtained
	<u>Habilitation services</u>	<b>Occupational Therapy:</b> \$20 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Speech Therapy:</b> No charge; <u>deductible</u> does not apply	<b>Occupational Therapy:</b> 20% <u>coinsurance</u> <b>Speech Therapy:</b> 20% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	<b>Out-of-Network <a href="#">preauthorization</a></b> required. \$500 penalty if not obtained
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	For inpatient see “If you have a hospital stay”
<b>If your child needs dental or eye care</b>	Children’s eye exam	<b>Optometrist:</b> \$20 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Ophthalmologists: Tier 1:</b> \$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Tier 2:</b> \$60 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Tier 3:</b> \$75 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	<b>Optometrist:</b> 20% <a href="#">coinsurance</a> <b>Ophthalmologists:</b> 20% <a href="#">coinsurance</a>	- 1 exam every 24 months
	Children’s glasses	Not covered		None
	Children’s dental check-up	Not covered		None
<b>Excluded Services &amp; Other Covered Services:</b>				
<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</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>Most Dental Care (Adult)</li> <li>Private-duty nursing</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 (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)</b>				
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic Care - 20 visits/ year</li> <li>Hearing Aids - \$2,000/ hearing aid every 24 months/ impaired ear up to age 22</li> </ul>		<ul style="list-style-type: none"> <li>Hearing Aids - up to \$1,700 every 2 years for age 22 or older</li> <li>Infertility Treatment - 5 cycles advanced reproductive technology/ lifetime</li> </ul>		<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult) - 1 exam every 24 months</li> </ul>

## 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 on how 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>

## Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

## 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 (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall deductible \$600</li> <li>■ <a href="#">Specialist copayment</a> \$30</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$275</li> <li>■ Other <a href="#">copayment</a> \$0</li> </ul> <p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist visit</a> (<i>anesthesia</i>)</p>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall deductible \$600</li> <li>■ <a href="#">Specialist copayment</a> \$30</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$275</li> <li>■ Other <a href="#">copayment</a> \$0</li> </ul> <p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall deductible \$600</li> <li>■ <a href="#">Specialist copayment</a> \$30</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$275</li> <li>■ Other <a href="#">copayment</a> \$0</li> </ul> <p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>
<b>Total Example Cost</b> <span style="float: right;"><b>\$12,700</b></span>	<b>Total Example Cost</b> <span style="float: right;"><b>\$5,600</b></span>	<b>Total Example Cost</b> <span style="float: right;"><b>\$2,800</b></span>
<b>In this example, Peg would pay:</b>	<b>In this example, Joe would pay:</b>	<b>In this example, Mia would pay:</b>
<i>Cost Sharing</i>	<i>Cost Sharing</i>	<i>Cost Sharing</i>
<a href="#">Deductibles</a> \$600	<a href="#">Deductibles</a> \$300	<a href="#">Deductibles</a> \$500
<a href="#">Copayments</a> \$300	<a href="#">Copayments</a> \$1,100	<a href="#">Copayments</a> \$200
<a href="#">Coinsurance</a> \$0	<a href="#">Coinsurance</a> \$0	<a href="#">Coinsurance</a> \$50
<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 \$0	Limits or exclusions \$0
<b>The total Peg would pay is</b> <span style="float: right;"><b>\$900</b></span>	<b>The total Joe would pay is</b> <span style="float: right;"><b>\$1,400</b></span>	<b>The total Mia would pay is</b> <span style="float: right;"><b>\$700</b></span>

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. إتصل على 1 888-333-4742

(TTY: 711)

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**ខ្មែរ (Cambodian)** ចូរសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, 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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Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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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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**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 मुफ्तमें 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 ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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)

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