


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, [www.harvardpilgrim.org/public/eoc?pdid=PD0000201915](http://www.harvardpilgrim.org/public/eoc?pdid=PD0000201915). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view 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> ?                             | In-Network: \$500 member / \$1,000 family<br>Out-of-Network: \$1,000 member / \$2,000 family<br>Benefits are administered on a Plan Year basis.  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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>Prescription drugs</u> , <u>emergency room care</u> , and the following In-Network services: <u>preventive care</u> , <u>provider office visits</u> , services from Flex <u>Providers</u> , and Non-hospital based imaging, <u>Rehabilitation services</u> , and <u>Habilitation services</u> 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| 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> ?       | In-Network: \$7,000 member / \$14,000 family<br>Out-of-Network: \$14,000 member / \$28,000 family  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |

| Important Questions  | Answers  | Why This Matters   |
|--|--|--|
| What is not included in the <u>out-of-pocket limit</u> ?   | Pediatric Dental Care, <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> for services, 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.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>network 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 <u>plan's 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 <u>provider's</u> charge and what your plan 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> ? | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |

 All copayment and coinsurance costs shown in this chart are 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<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               | Level 1: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply   | 20% <u>coinsurance</u>                             | \$0 <u>copay</u> for first visit   |
|   | <u>Specialist</u> visit  | Level 1: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Level 2: \$50 <u>copay</u> / visit; <u>deductible</u> does not apply | 20% <u>coinsurance</u>                             | None   |
|   | <u>Preventive care</u> /<br><u>screening</u> /<br>immunization | No charge; <u>deductible</u> does not apply  | 20% <u>coinsurance</u>                             | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. |

| 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   | <a href="#">Diagnostic test</a> (x-ray, blood work) | X-rays: \$50 <a href="#">copay</a> / visit<br>Laboratory: Flex <a href="#">Providers</a> : No charge; <a href="#">deductible</a> does not apply<br>Other Plan <a href="#">Providers</a> : \$45 <a href="#">copay</a> / visit  | X-rays: 20% <a href="#">coinsurance</a><br>Laboratory: 20% <a href="#">coinsurance</a> | None  |
|  | Imaging (CT/PET scans, MRIs)                        | Non-Hospital Based: \$200 <a href="#">copay</a> / procedure; <a href="#">deductible</a> does not apply<br>Hospital Based: \$300 <a href="#">copay</a> / procedure   | 20% <a href="#">coinsurance</a>  | Out-of-Network <a href="#">preauthorization</a> required. \$500 penalty if not obtained   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.harvardpilgrim.org/2025CoreMA5T">www.harvardpilgrim.org/2025CoreMA5T</a> . | Generic drugs                                       | 30-Day Retail Tier 1: \$5 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 1: \$10 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>30-Day Retail Tier 2: \$30 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 2: \$60 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply | Not covered  | Core MA formulary - covers a limited list; not all drugs are covered<br>You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable <a href="#">cost sharing</a> . Covered only outside of service area. |
|  | Preferred brand drugs                               | 30-Day Retail Tier 3: \$60 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 3: \$120 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply   | Not covered  |   |
|  | Non-preferred brand drugs                           | 30-Day Retail Tier 4: \$100 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 4: \$300 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply  | Not covered  |   |

| 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)  |   |
|   | <a href="#">Specialty drugs</a>                  | 30-Day Retail Tier 4: \$100 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 4: \$300 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply<br>30-Day Retail Tier 5: 20% <a href="#">coinsurance</a> up to \$250; <a href="#">deductible</a> does not apply<br>90-Day Mail Tier 5: 20% <a href="#">coinsurance</a> up to \$750; <a href="#">deductible</a> does not apply | Not covered   | Some drugs must be obtained through a Specialty Pharmacy.                               |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | Flex <a href="#">Providers</a> : \$50 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply<br>Other Plan <a href="#">Providers</a> : \$300 <a href="#">copay</a> / visit   | 20% <a href="#">coinsurance</a>                     | Out-of-Network <a href="#">preauthorization</a> required. \$500 penalty if not obtained |
|   | Physician/surgeon fees                           | Flex <a href="#">Providers</a> : No charge; <a href="#">deductible</a> does not apply<br>Other Plan <a href="#">Providers</a> : No charge; <a href="#">deductible</a> does not apply   | 20% <a href="#">coinsurance</a>                     |   |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$300 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply   |   | None  |
|   | <a href="#">Emergency medical transportation</a> | No charge  |   | None  |
|   | <a href="#">Urgent care</a>                      | Urgent care center: \$50 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply  | Urgent care center: 20% <a href="#">coinsurance</a> | <a href="#">Cost sharing</a> may vary based on Urgent Care location.                    |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | \$250 <a href="#">copay</a> / admit  | 20% <a href="#">coinsurance</a>                     | Out-of-Network <a href="#">preauthorization</a> required. \$500 penalty if not obtained |
|   | Physician/surgeon fee                            | No charge  | 20% <a href="#">coinsurance</a>                     |   |

| 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 mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 <u>copay</u> / visit; <u>deductible</u> does not apply   | 20% <u>coinsurance</u>   | \$0 <u>copay</u> for first mental health/substance abuse visit  |
|   | Inpatient services                        | \$250 <u>copay</u> / admit  | 20% <u>coinsurance</u>   | None  |
| If you are pregnant   | Office visits                             | \$25 <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>   |   |
|   | Childbirth/delivery facility services     | \$250 <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>            | Physical Therapy:<br>Non-hospital based: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Hospital based: \$50 <u>copay</u> / visit     | Physical Therapy: 20% <u>coinsurance</u><br>Occupational Therapy: 20% <u>coinsurance</u><br>Speech Therapy: 20% <u>coinsurance</u> | Physical & Occupational Therapy - 60 combined visits/ Plan Year<br>Out-of-Network <u>preauthorization</u> required. \$500 penalty if not obtained |
|   | <u>Habilitation services</u>              | Occupational Therapy:<br>Non-hospital based: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Hospital based: \$50 <u>copay</u> / visit |  |   |
|   |   | Speech Therapy:<br>Non-hospital based: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply<br>Hospital based: \$50 <u>copay</u> / visit       |  |   |
|   |   |   |  |   |
|   | <u>Skilled nursing care</u>               | \$250 <u>copay</u> / admit  | 20% <u>coinsurance</u>   | - 100 days/ Plan Year   |

| 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) |   |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>                    | - 1 synthetic monofilament wig/ Plan Year<br>Out-of-Network <a href="#">preauthorization</a> required.<br>\$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”   |
| If your child needs dental or eye care | Children’s eye exam                       | \$25 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply                 | 20% <a href="#">coinsurance</a>                    | 1 exam/Plan Year  |
|  | Children’s glasses                        | Reimbursed first \$50, then 50% of covered charges; <a href="#">deductible</a> does not apply |  | Frames & lenses OR contacts every 12 months up to end of month child turns 19   |
|  | Children’s dental check-up                | Not covered   |  | Off exchange plans <b>must</b> have separate coverage   |

**Excluded Services & Other Covered Services:**

| Services Your <a href="#">Plan</a> Does NOT Cover (This isn’t a complete list. Check your policy or <a href="#">plan</a> document for other <a href="#">excluded services</a> .) |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>  | <ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (except for diabetes or systemic circulatory diseases)</li> <li>• Services that are not Medically Necessary</li> </ul> |

| Other Covered Services (This isn’t a complete list. Check your policy or <a href="#">plan</a> document for other covered services and your costs for these services.) |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic Care</li> </ul>                         | <ul style="list-style-type: none"> <li>• Hearing Aids - \$2,000/ hearing aid every 36 months/ impaired ear up to age 22</li> <li>• Infertility Treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult) - 1 exam/ Plan Year</li> <li>• Weight Loss Programs - 3 months of Weight Watchers traditional OR at Work/ Plan Year</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 Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-888-333-4742. 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.  
1 Wellness Way  
Canton, MA 02021-1166  
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**

[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 plan 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 section.

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 ([deductibles](#), [copayments](#) 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) |                |
|---|-----------------|--|----------------|---|----------------|
| ■ <a href="#">The plan's overall deductible</a>   | \$500           | ■ <a href="#">The plan's overall deductible</a>  | \$500          | ■ <a href="#">The plan's overall deductible</a>                               | \$500          |
| ■ <a href="#">Specialist copayment</a>  | \$50            | ■ <a href="#">Specialist copayment</a>   | \$50           | ■ <a href="#">Specialist copayment</a>  | \$50           |
| ■ <a href="#">Hospital (facility) copayment</a>   | \$250           | ■ <a href="#">Hospital (facility) copayment</a>  | \$250          | ■ <a href="#">Hospital (facility) copayment</a>                               | \$250          |
| ■ <a href="#">Other copayment</a>   | \$0             | ■ <a href="#">Other copayment</a>  | \$0            | ■ <a href="#">Other copayment</a>   | \$50           |
| <b>This EXAMPLE event includes services like:</b>                                       |                 | <b>This EXAMPLE event includes services like:</b>  |                | <b>This EXAMPLE event includes services like:</b>                             |                |
| <a href="#">Specialist</a> office visits ( <i>prenatal care</i> )                       |                 | <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> )          |                | <a href="#">Emergency room care</a> ( <i>including medical supplies</i> )     |                |
| Childbirth/Delivery Professional Services   |                 | <a href="#">Diagnostic tests</a> ( <i>blood work</i> )   |                | <a href="#">Diagnostic test</a> ( <i>x-ray</i> )                              |                |
| Childbirth/Delivery Facility Services   |                 | <a href="#">Prescription drugs</a>   |                | <a href="#">Durable medical equipment</a> ( <i>crutches</i> )                 |                |
| <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> )                  |                 | <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )                                   |                | <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )           |                |
| <a href="#">Specialist</a> visit ( <i>anesthesia</i> )                                  |                 |  |                |   |                |
| <b>Total Example Cost</b>   | <b>\$12,700</b> | <b>Total Example Cost</b>  | <b>\$5,600</b> | <b>Total Example Cost</b>   | <b>\$2,800</b> |
| <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>   | \$500           | <a href="#">Deductibles</a>  | \$0            | <a href="#">Deductibles</a>   | \$500          |
| <a href="#">Copayments</a>  | \$400           | <a href="#">Copayments</a>   | \$1,800        | <a href="#">Copayments</a>  | \$600          |
| <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>   | <b>\$900</b>    | <b>The total Joe would pay is</b>  | <b>\$1,800</b> | <b>The total Mia would pay is</b>   | <b>\$1,150</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 1-877-907-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (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 1-877-907-4742 (TTY: 711)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 1-877-907-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).


العربية (Arabic)

إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 877-907-4742 (TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ដូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

 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. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

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**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

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**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (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. 1-877-907-4742 (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. 1-877-907-4742 (TTY: 711)

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**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-907-4742 (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 1-877-907-4742 (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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