




**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 copayments and coinsurance cost shown in this chart after your deductible has been met, if a deductible 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: No charge Laboratory: Select Providers: No charge; <u>deductible</u> does not apply. Other Plan Providers: 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.

**PPO 2000 - FLEX**

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

**Coverage Period:** 12/01/2020 — 11/30/2021  
**Coverage for:** Individual + Family | **Plan Type:** PPO



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-page?pdid=PD0000006856](http://www.harvardpilgrim.org/public/eoc-page?pdid=PD0000006856). 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 <a href="#">deductible</a> ?	<b>In-Network:</b> \$2,000 member / \$4,000 family <b>Out-of-Network:</b> \$4,000 member / \$8,000 family Benefits are administered on a Plan Year basis.	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Prescription drugs, <a href="#">emergency room care</a> , and the following <b>In-Network</b> services: <a href="#">preventive care</a> , <a href="#">provider</a> office visits, services from <b>Flex Providers</b> , and <b>Non-hospital based</b> imaging, <a href="#">Rehabilitation services</a> and <a href="#">Habilitation services</a> are covered before you meet your <a href="#">deductible</a> .	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.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network:</b> \$6,500 member / \$13,000 family <b>Out-of-Network:</b> \$13,000 member / \$26,000 family	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.

**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> ?	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> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance cost 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 (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: \$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 Level 2: \$50 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	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 plan will pay for.

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

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)	X-rays: \$45 <a href="#">copay</a> / visit Laboratory: <b>Flex Providers:</b> No charge; <a href="#">deductible</a> does not apply <b>Other Plan Providers:</b> \$45 <a href="#">copay</a> / visit	X-rays: 20% <a href="#">coinsurance</a> Laboratory: 20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	<b>Physician/Non-Hospital Based:</b> \$200 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Hospital Based:</b> \$300 <a href="#">copay</a> / procedure	20% <a href="#">coinsurance</a>	<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.harvardpilgrim.org/2020Value5T">www.harvardpilgrim.org/2020Value5T</a> .	Generic drugs	<b>30-Day Retail Tier 1:</b> \$5 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 1:</b> \$10 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>30-Day Retail Tier 2:</b> \$30 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 2:</b> \$60 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply		Value formulary - covers a limited list; not all drugs are covered
	Preferred brand drugs	<b>30-Day Retail Tier 3:</b> \$60 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 3:</b> \$120 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply		Some generic drugs are in this tier
	Non-preferred brand drugs	<b>30-Day Retail Tier 4:</b> \$100 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 4:</b> \$300 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply		Same as above.
	<a href="#">Specialty drugs</a>	<b>30-Day Retail Tier 4:</b> \$100 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 4:</b> \$300 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply		Some drugs must be obtained through a Specialty Pharmacy

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

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)	
		<b>30-Day Retail Tier 5:</b> 20% <a href="#">coinsurance</a> up to \$250; <a href="#">deductible</a> does not apply <b>90-Day Mail Tier 5:</b> 20% <a href="#">coinsurance</a> up to \$750; <a href="#">deductible</a> does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<b>Flex Providers:</b> \$75 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Other Plan Providers:</b> \$300 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	<b>Out-of-Network <a href="#">preauthorization</a></b> required. \$500 penalty if not obtained
	Physician/surgeon fees	<b>Flex Providers:</b> No charge; <a href="#">deductible</a> does not apply. <b>Other Plan Providers:</b> No charge	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>	<b>Convenience care clinic:</b> \$25 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Urgent care center:</b> \$50 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply <b>Hospital urgent care center:</b> \$50 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	<b>Convenience care clinic:</b> 20% <a href="#">coinsurance</a> <b>Urgent care center:</b> 20% <a href="#">coinsurance</a> <b>Hospital urgent care center:</b> 20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> / admit	20% <a href="#">coinsurance</a>	<b>Out-of-Network <a href="#">preauthorization</a></b> required. \$500 penalty if not obtained
	Physician/surgeon fee	No charge	20% <a href="#">coinsurance</a>	

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

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 mental health, behavioral health, or substance abuse needs	Outpatient services	Level 1: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	\$0 <u>copay</u> for first outpatient mental health/substance abuse visit <b>Out-of-Network <u>preauthorization</u></b> required. \$500 penalty if not obtained
	Inpatient services	\$250 <u>copay</u> / admit	20% <u>coinsurance</u>	
If you are pregnant	Office visits	Level 1: \$25 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	<b>Cost sharing</b> does not apply for <b><u>preventive services</u></b> .
	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>	<b>Non-hospital based:</b> \$25 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Hospital based:</b> \$50 <u>copay</u> / visit	20% <u>coinsurance</u>	Physical & Occupational Therapy – 60 combined visits/ Plan Year <b>Out-of-Network <u>preauthorization</u></b> required. \$500 penalty if not obtained
	<u>Habilitation services</u>	<b>Non-hospital based:</b> \$25 <u>copay</u> / visit; <u>deductible</u> does not apply <b>Hospital based:</b> \$50 <u>copay</u> / visit	20% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$250 <u>copay</u> / admit	20% <u>coinsurance</u>	– 100 days/ Plan Year

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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>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	– 1 synthetic monofilament wig/ Plan Year <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>Level 1:</b> \$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	No charge; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	– 2 exams/ 12 months up to end of month child turns 19
<b>Excluded Services &amp; Other Covered Services:</b>				
<b>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>.)</b>				
<ul style="list-style-type: none"> <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> </ul>		
<b>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.)</b>				
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture - 20 visits/ Plan Year</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 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 (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 plan's overall deductible \$2,000</li> <li>■ Specialist <a href="#">copayment</a> \$50</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$250</li> <li>■ Other <a href="#">copayment</a> \$0</li> </ul> <p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>	<ul style="list-style-type: none"> <li>■ The plan's overall deductible \$2,000</li> <li>■ Specialist <a href="#">copayment</a> \$50</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$250</li> <li>■ Other <a href="#">copayment</a> \$0</li> </ul> <p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>	<ul style="list-style-type: none"> <li>■ The plan's overall deductible \$2,000</li> <li>■ Specialist <a href="#">copayment</a> \$50</li> <li>■ Hospital (facility) <a href="#">copayment</a> \$250</li> <li>■ Other <a href="#">copayment</a> \$45</li> </ul> <p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>
<b>Total Example Cost</b> \$12,731	<b>Total Example Cost</b> \$7,389	<b>Total Example Cost</b> \$1,925
<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> \$2,000	<a href="#">Deductibles</a> \$0	<a href="#">Deductibles</a> \$1,260
<a href="#">Copayments</a> \$300	<a href="#">Copayments</a> \$2,490	<a href="#">Copayments</a> \$180
<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> \$2,300	<b>The total Joe would pay is</b> \$2,520	<b>The total Mia would pay is</b> \$1,440

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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**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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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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