University of Rochester
YOUR HSA
Pharmacy Benefits

NAVITUS

Our business is personal

Introduction

This booklet explains the prescription drug benefits available to you under the University of Rochester Welfare Benefits Plan (the "Plan") for Faculty & Staff of the University of Rochester effective as of January 1, 2024. The booklet is intended to be read with, and considered as part of, the Plan. This booklet also forms part of the summary plan description for the Plan. Unless otherwise addressed in this booklet, please refer to the "Summary Plan Description for the University of Rochester Welfare Benefits Plan" (also known as the "wrap document SPD") for more information regarding your prescription drug benefits. Enrollment in the University of Rochester medical plans comprises medical and prescription drug coverage. To view summary plan descriptions for medical coverage and the wrap document SPD, please visit https://www.rochester.edu/human-resources/benefits/legal-notices/.

The Plan Sponsor delegates its responsibility with respect to the payment of claims to the Claims Administrator.

The Plan Sponsor fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

If the Plan is terminated, the rights of a Covered Person are limited to expenses incurred before the termination date. All amendments to the Plan shall become effective as of the date established by the Plan Sponsor.

Contact Information	
Customer Care	833-210-5965 711 (TTY) 24 hours a day, 7 days a week
Prescription Claims	Navitus Health Solutions Attn: Claims Department PO Box 999 Appleton, WI 54912-0999 Fax: 855-668-8550 (toll-free)
Navitus Website	Navitus.com/members
Member Portal	Memberportal.navitus.com
Mail Order	Costco Mail Order 800-607-6861 Pharmacy.costco.com
Specialty Pharmacy	UR Specialty Pharmacy 855-340-4767 Urmc.rochester.edu/pharmacy Lumicera Health Services 855-847-9553 Lumicera.com

Prescription Drug Schedule of Benefits – HDHP Option

	DOMESTIC PHARMACY (Subject to the Allowed Amount) **You Pay**	**PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
CALENDAR YEAR DEDUCTIBLE (Medical and Prescription Drug combined)			
Individual	$1,600		Not Covered
Two-person	$3,200		Not Covered
Employee plus Children	$3,200		Not Covered
Family	$3,200		Not Covered
If you have two-person, Employee plus Children, or family coverage, each person within a family or any combination of family members must satisfy the two-person, Employee plus Children, or family Deductible stated above before the Plan will begin to pay any Covered expense for any covered family member for the Calendar Year.			
If you use a combination of Domestic Network Providers, Participating Providers and Non-Participating Providers, the total Deductible amount required to be paid for Domestic Network Providers and Participating Providers will never exceed the amount shown above for Participating Providers; however, the total Deductible amount required to be paid for Non-Participating Providers is separate from the Domestic Network Provider and Participating Provider Deductible amounts (combined) and are not combined. This means that you will be required to satisfy the Deductible amount for Domestic Network Providers and Participating Providers (combined) and Non-Participating Providers separately. The amounts you pay towards satisfaction of the Domestic Network Provider Deductible and Participating Provider Deductible (combined) do not count towards satisfaction of the Non-Participating Provider Deductible and the amounts you pay towards satisfaction of the Non-Participating Provider Deductible do not count towards satisfaction of the Domestic Network Provider Deductible and Participating Provider Deductible (combined).			
CALENDAR YEAR OUT-OF-POCKET LIMIT - EMPLOYEES OVER $68,900 (Medical and Prescription Drug combined)			
Individual	$3,000		Not Covered
Two-person	$6,000		Not Covered
Employee plus Children	$6,000		Not Covered
Family	$6,000		Not Covered
Employee Salary over $68,900: If you have other than individual coverage, once a person within a family has paid $6,000 for Domestic Network Providers (including Domestic Network Pharmacies), $8,350 for Participating Providers (including a maximum of $6,000 applied towards Participating Pharmacies), or $13,500 (for Non-Participating Providers) in Coinsurance, Copayments, and Deductibles in a Calendar Year, the Plan will provide coverage for 100% of the Allowed Amount for the rest of that Calendar Year for that person.			
CALENDAR YEAR OUT-OF-POCKET LIMIT - EMPLOYEES UNDER $68,900 (Medical and Prescription Drug combined)			
Individual	$2,500		Not Covered

	DOMESTIC PHARMACY (Subject to the Allowed Amount) **You Pay**	**PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
Two-person	$5,000		Not Covered
Employee plus Children	$5,000		Not Covered
Family	$5,000		Not Covered
Employee Salary under $68,900: If you have other than individual coverage, one or more people within a family must satisfy the full two-person, Employee plus Children, or family Out-of-Pocket Limit stated above for Domestic Network Providers, Participating Providers or Non-Participating Providers (as applicable). Once the two-person, Employee plus Children, or family Out-of-Pocket Limit has been satisfied the Plan will provide coverage at 100% of the Allowed Amount for any person in that family covered under the Plan for the rest of the Calendar Year.			
If you use a combination of Domestic Network Providers, Participating Providers and Non-Participating Providers, the Out-of-Pocket Limit required to be paid for Domestic Network Providers and Participating Providers will never exceed the amount shown above for Domestic Network Provider/Participating Providers; however, the total Out-of-Pocket Limit amount required to be paid for Non-Participating Providers is separate from the Domestic Network Provider and Participating Provider Out-of-Pocket Limit amounts (combined) and are not combined. This means that you will be required to satisfy the Out-of-Pocket Limit amount for Domestic Network Providers and Participating Providers (combined) and Non-Participating Providers separately. The amounts you pay towards satisfaction of the Domestic Network Provider Out-of-Pocket Limit and Participating Provider Out-of-Pocket Limit (combined) do not count towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit and the amounts you pay towards satisfaction of the Non-Participating Provider Out-of-Pocket Limit do not count towards satisfaction of the Domestic Network Provider Out-of-Pocket Limit and Participating Provider Out-of-Pocket Limit (combined)			
Retail Pharmacy – 30-day supply			
Tier 1	$15 Copayment, after Deductible		Not Covered
Tier 2	20% Coinsurance, after Deductible, minimum $25 and a maximum $60		Not Covered
Tier 3	35% Coinsurance, after Deductible, minimum $50 and maximum $120		Not Covered
Mail Order Pharmacy – 90-day supply			
Tier 1	$37.50 Copayment, after Deductible		Not Covered
Tier 2	20% Coinsurance, after Deductible, minimum $62.50 and maximum $150		Not Covered
Tier 3	35% Coinsurance, after Deductible, minimum $125 and maximum $300		Not Covered
Insulin – 30-day supply	Same Cost-Sharing as retail and mail order above but limited to a max of $100		Not Covered
Specialty Drugs*	Same Cost-Sharing and limits as retail and mail order above reduced by 25%	Not Covered	Not Covered

	DOMESTIC PHARMACY (Subject to the Allowed Amount) **You Pay**	**PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
***Specialty Drugs.** Specialty drugs are only covered under the Plan if they are filled at the University of Rochester Employee Pharmacy. Specialty drugs filled outside of the University of Rochester Employee Pharmacy will not be covered and you will be responsible for the full cost of the drug. Such cost will not apply to your Deductible or Out-of-Pocket Maximum. The University of Rochester Employee Pharmacy is dedicated exclusively to UR employees, volunteers, non-Medicare eligible retirees, and eligible dependents. The pharmacy features potential savings for employees and their families who are covered under this Plan. If you have a specialty drug filled at the University of Rochester Employee Pharmacy your Copayment, as specified under the Prescription Drug Schedule of Benefits, will be reduced by 25%. In addition, you will receive a 90-day supply of any maintenance medications and free delivery of any medication if you are an off-site employee. For additional information on the University of Rochester Employee Pharmacy, including instructions on how to transfer any existing prescriptions, please visit www.urmc.rochester.edu/pharmacy/pharmacies/employee.aspx.			
Lifetime Maximum for Infertility Prescription Drugs: Limited to an aggregated amount of $60,000 combined with medical in vitro fertilization services (Domestic Network Providers, Participating Providers and Non-Participating Providers combined).			
Preauthorization Requirement. Certain Prescription Drugs require Preauthorization. If you don't get Preauthorization, your Prescription Drug will not be Covered. You can view a list of Prescription Drugs that require Preauthorization by visiting www.navitus.com. You may also request a copy, free of charge by calling the telephone number on your identification card.			
Mandatory Generic. The Plan requires pharmacies to dispense Generic Drugs, when available. If you or your provider chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable Cost-Sharing for the higher cost drug, plus the cost-difference between the Generic Drug and the higher cost drug. This cost difference will not apply to your Out-of-Pocket Limit.			
Formulary. The list that identifies those Prescription Drugs for which coverage may be available under this Plan. This list is subject to periodic review and modification. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.navitus.com or by calling the number on your ID card. Over-the-Counter (OTC) products, drugs, medications, tests, or devices are not covered under the Plan, unless otherwise required by law or otherwise specified in the formulary.			

Claims Procedures

This section generally describes the pharmacy benefit claims and appeals procedures. Please refer to the wrap document SPD for a fully summary of your rights and responsibilities with respect to claims and appeals under the Plan. To the extent there is a conflict between the claims procedures in this summary plan description and the wrap document SPD, the wrap document SPD will govern, unless otherwise specified.

Filing Claims

To begin the process, simply present your member ID card at the pharmacy. Your ID card contains information the pharmacy needs to fill your prescription and charge the correct copayment.
To file a paper claim to obtain a reimbursement from the Plan for any prescription that is paid in full at the time that is filled, follow the instructions below:

1. Log on to the Member Section of www.navitus.com to obtain the Direct Member Claim Form.
2. Complete all the information on the form. Please note: forms missing information are returned without payment.
3. Sign and date the Certification Statement.
4. Submit a separate form for each family member.
5. If the member has other insurance coverage, attach a copy of the "Explanations of Benefits" or "Denial Notification" from the primary insurance carrier.
6. Keep a copy for your records. Documents submitted will not be returned.
7. Mail or fax the claim form and the original receipt for processing. The mailing address and fax number are listed on the claim form.

Appealing a Claim Denial

When you have a concern about a benefit, claim or other service, please call Navitus Customer Care at the toll-free number listed on your card. Customer Care Specialists will answer your questions and resolve your concerns quickly.

A Navitus Health Solutions pharmacist carefully reviews all of the information that is provided and applies the terms of your pharmacy benefit Plan to your request for review. All information is reviewed on a case-by-case basis, specific to each Plan member who submitted the appeal (or on whose behalf an appeal was submitted) and the circumstances surrounding the request. The pharmacist who conducts the review of your appeal is not involved in the original determination and is not a subordinate of the person who made the original denial.

If your issue or concern is not resolved by calling Customer Care, you have the right to file a written appeal with Navitus. Please send this appeal, along with any related information from your doctor, to:

Mail:
Navitus Health Solutions
Attn: Appeals Department
P.O. Box 999
Appleton, WI 54912-0999

Fax:
Navitus Health Solutions
855-668-8550
Attn: Appeals Department

Standard Grievance: Members will receive notification of the outcome of the investigation within thirty (30) calendar days of receipt of the grievance. An additional 14-day extension may be requested by the member of Navitus (if justified). If Navitus extends the deadline, Navitus will immediately notify the member in writing of the reasons for the delay.

Expedited Grievance: Members have the right to file an expedited grievance if Navitus refused to grant a request for an expedited coverage determination, expedited redetermination, and the beneficiary has not yet purchased or reached the drug that is in dispute

a. The Grievance and Appeals Coordinator will verbally notify the member of its decision within twenty-four (24) hours.
b. The Grievance and Appeals Coordinator will send a written notification of the decision within three (3) calendar days of the verbal notification.

Upon request, Navitus will disclose grievance data to the member free of charge.
If a member, provider, or appointed representative indicates orally or in writing that they no longer want to proceed with a grievance request, it will be considered withdrawn.
All Navitus logs and documentation will be stored at the Navitus campus for a minimum period of ten (10) years and is subject to review by CMS and all other approved entities.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent external review pursuant to federal law.

If your final internal appeal is denied, you will be notified in writing that your claim is eligible for external review and you will be informed of the steps necessary to request an external review. If you decide to seek external review, an independent external review organization ("IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise.

You must submit your request for external review to Navitus within four (4) months of the notice of your final internal adverse determination.

A request for an external review must be in writing unless Navitus determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Navitus' internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Navitus' decision, can be sent between Navitus and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact Navitus Customer Care at 833-210-5965.
All other requests for external review should be submitted in writing unless Navitus determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Mail:
Navitus Health Solutions
Attn: Appeals Department
P.O. Box 999
Appleton, WI 54912-0999

Fax:
Navitus Health Solutions
855-668-8550
Attn: Appeals Department

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent external review.

Requirement to file an Appeal before taking further legal action

No legal action of any kind related to a benefit decision may be filed by you in any other forum, unless it is commenced in accordance with the statute of limitations and exhaustion of administrative remedies requirements under the Plan. Refer to the wrap document SPD for more information..

Navitus reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services.

Definitions

Allowed Amount:
Please refer to medical booklets for definition.

Benefit Maximum:
The total amount the Plan will pay on the pharmacy benefit. It is usually within a given timeframe.

Calendar Year:
The twelve-month period beginning on January 1 and ending on December 31 each year.

Coinsurance:
A fixed percentage of the cost of each prescription that the Plan member needs to pay. Coinsurance can be applied to all drugs or certain types of drugs.

Copayment:
A fixed dollar amount for each prescription that is paid by the Plan member. The copayment may vary according to the type of drug.

Cost-Sharing:
Amounts you must pay for Covered Services/Products, expressed as Coinsurance, Copayments and/or Deductibles.

Covered Person:
A Covered Employee, Retiree and each of his or her Dependents covered under the Plan.

Cover, Covered, or Covered Services(s)/Products:
The Medically Necessary items or services paid for, arranged, or authorized for a Covered Person under the terms and conditions of this Plan.

Deductible:
The Plan member pays the whole cost of each prescription, up to a specified dollar amount. Once that dollar amount is reached, the prescription drug benefit takes effect.

Domestic Network Provider:
Please refer to medical booklets for definition.

Domestic Pharmacy:
University of Rochester Pharmacies within the domestic network.

Drug Formulary or Preferred Drug List:

Covered drugs that are covered by the pharmacy benefit plan.

Drug Utilization Review:
A process done by Navitus where a Plan member's prescription drug use is looked at to find situations where we can improve the member's health and drug costs.

Excluded Product:
This is a drug that is not listed on the formulary. The drug is not available at a reduced copayment or coinsurance amount under normal conditions.

Generic Drug:
Competitors to a branded product that has an expired patent. Generics are considered identical to the brand product. Licensed under an Abbreviated New Drug Application by the FDA.

Grievance Process:
The process by which Plan members (and their authorized representatives) may appeal coverage decisions.

Mail Order Pharmacy Services:
A service that allows Plan members to obtain maintenance drugs without physically visiting a pharmacy. Mail order often allows Plan members to get more than a one-month supply of medication at one time. Navitus uses an outside vendor for mail services. Please login to Navi-Gate for Members for more information about your mail order service.

Mandatory Generic Substitution:
This is a program where Plan members have to use generic drug products when available. Plan members who choose to use the brand product rather than the generic drug product have to pay a higher copayment, a greater coinsurance amount, or the full price of the drug.

MCO:
Managed Care Organization

Multi-Tier Benefit Plan:
The amount a Plan member must pay for a drug product is determined by what "tier" the medication has been placed into. Multi-tier benefit plans generally have between two and five tiers.
Network Providers:

Non-Participating Pharmacy:
A pharmacy that has not entered into an agreement with the Pharmacy Benefit Manager to provide Prescription Drugs to Covered Persons. The Plan will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy.

Non-Participating Provider:

Please refer to medical booklets for definition.

Out-of-Pocket Maximum:
A fixed dollar limit on a Plan member's out-of-pocket expenses. After reaching the limit, drugs can be filled at a lower cost or at zero cost to the member. The amount owed depends on the member's benefit structure. All drugs or only certain types of prescriptions a member receives may go toward the out-of-pocket maximum.

Participating Provider:
Please refer to medical booklets for definition.

Pharmacy Benefit Manager (PBM):
A pharmacy benefit manager (PBM) is an administrator of a prescription drug program. A PBM is primarily responsible for processing and paying prescription drug claims. Technically, PBMs are private firms that contract with employers, insurers and public and private plan sponsors, but HMOs, managed care organizations, state governments, etc. also can function as PBMs.

Pharmacy Benefit Plan:
Benefit plan or design determines what drugs the plan does and does not cover, in what quantities, from what pharmacies and other drug sources, and at what out-of-pocket cost to Plan members.

Pharmacy Network:
A group of pharmacies with which a PBM contracts to provide pharmacy services to its clients.

Prescription Drug (also prescription medication, prescription medicine or prescription-only medication):
Apharmaceutical drug that is permitted to be dispensed only to those with a medical prescription. In contrast, over-the-counter drugs can be obtained without a prescription. The reason for this difference in substance control is the potential scope of misuse, from drug abuse to practicing medicine without a license and without sufficient education. Different jurisdictions have different definitions of what constitutes a prescription drug.

Prior Authorization:
The process where specified drugs on the formulary require extra review by clinical staff before they are covered by the benefit plan.

Specialty Drug:
A drug that is costly, requires special supply chain features (such as freezing or cold storage), typically indicated for a small group of patients, and where the patients may need special case management services. This is the broadest definition. There is no single agreed-upon definition, so sometimes specialty drug will only mean high-cost. For instance, specialty drugs in the Medicare Part D program are only defined by cost — currently $670/month (2018) — and indexed annually.

Specialty Pharmacy Services:
Pharmacy services associated with the delivery of high-cost prescription drugs to treat specific conditions. These drugs often require special handling such as refrigeration. To receive these drugs through your benefit plan, you will need to fill them at UR Employee Pharmacy. Ordering is simple. Just call 585-273-4767. They will help you and your prescriber get set up. For urgent questions 24/7, call 855-340-4767.

Verbal Complaint:
Any oral expression of dissatisfaction expressed to Navitus Health Solutions by a Plan member, their healthcare provider or authorized representative about the products or services of Navitus Health Solutions or its vendors (with whom Navitus has a direct contract). This definition does not include appeals or grievance.

Written Complaint:
Any written expression of dissatisfaction expressed to Navitus Health Solutions by a Plan member, their healthcare provider or authorized representative about the products or services of Navitus Health Solutions or its vendors (with whom Navitus has a direct contract). This definition does not include appeals or grievance.

Written Inquiry:
Any written request for information that does not express dissatisfaction or invoke a complaint, such as a routine question about a benefit.

July 2024

Notice of Nondiscrimination and Availability of Language Assistance Services

Discrimination is Against the Law

The University of Rochester Health Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). The University of Rochester Health Plans do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

The University of Rochester Health Plans:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Interpreter Services at (585) 275-4778.

If you believe that the University of Rochester Health Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can obtain a copy of the grievance procedure and/or file a grievance with:

Office of Total Rewards, 60 Corporate Woods, Suite 310, PO Box 270453, Rochester, NY 14627, Phone: (585) 275-2084, Fax: (585) 272-0227, Email: totalrewards@rochester.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Total Rewards is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at the University of Rochester Health Plans website(s): https://www.rochester.edu/human-resources/benefits/legal-notices/

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-585-275-4778 (email: Interpreter_Services@URMC.Rochester.edu) or speak to your provider."

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-585-275-4778 (correo electrónico: Interpreter_services@urmc.rochester.edu) o hable con su proveedor.

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-585-275-4778（電子郵件：Interpreter_Services@URMC.Rochester.edu）或與您的提供者討論。」

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-585-275-4778 (электронная почта: Interpreter_Services@URMC.Rochester.edu) или поговорите со своим поставщиком медицинских услуг.

ATANSYON: Si w pale kreyòl ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele 1-585-275-4778 (imel: Interpreter_Services@URMC.Rochester.edu) oswa pale ak founisè w la.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-585-275-4778(이메일: Interpreter_Services@URMC.Rochester.edu) 번으로 전화하거나 서비스 제공업체에 문의하십시오."

ATTENZIONE: Se parli italiano sono a tua disposizione servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-585-275-4778 (e-mail: Interpreter_Services@URMC.Rochester.edu) o parla con il tuo fornitore.

נאטיץ :אויב איר רעדט יידיש ,זענען די שפּראַך הילף סערוויסעס פּאר דיר פּריי פּריי .צונעמען אַידס און באַדינונגס פֿאַר פֿראַווייַדינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי .רופן 1-585-275-4778 (E-בריוו: Interpreter_Services@URMC.Rochester.edu) אָדער רעדן צו דיין שפּיַזער.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-585-275-4778 (ইমেল: Interpreter_Services@URMC.Rochester.edu) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-585-275-4778 (e-mail: Interpreter_Services@URMC.Rochester.edu) lub porozmawiaj ze swoim dostawcą.

تنبيه :إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك .تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا .اتصل بالرقم 1-585-275-4778)البريد الإلكتروني: Interpreter_Services@URMC.Rochester.edu) أو تحدث إلى مزود الخدمة الخاص بك.

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-585-275-4778 (e-mail : Interpreter_Services@URMC.Rochester.edu) ou parlez à votre fournisseur.

نوٹ :اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت لینگویج سپورٹ سروسز دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-585-275-4778 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ (ای میل: Interpreter_Services@URMC.Rochester.edu)

PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-585-275-4778 (email: Interpreter_Services@URMC.Rochester.edu) o makipag-usap sa iyong provider.

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Τα κατάλληλα βοηθητικά βοηθήματα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμες μορφές διατίθενται επίσης δωρεάν. Καλέστε το 1-585-275-4778 (email: Interpreter_Services@URMC.Rochester.edu) ή μιλήστε με τον παροχέα σας.

KUJDES: Nëse flisni shqip, ofrohen shërbime falas të asistencës gjuhësore. Ndihmat dhe shërbimet e duhura ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu në dispozicion pa pagesë. Telefononi 1-585-275-4778 (email: Interpreter_Services@URMC.Rochester.edu) ose flisni me ofruesin tuaj.

注意: 日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。 アクセシブルな形式で情報を提供するための適切な補助援助やサービスも無料で利用できます。 1-585-275-4778 (電子メール: Interpreter_Services@URMC.Rochester.edu) に電話するか、プロバイダーにお問い合わせください。

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायता और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-585-275-4778 पर कॉल करें (ईमेल: Interpreter_Services@URMC.Rochester.edu) या अपने प्रदाता से बात करें।