

Schedule of Benefits

Medicare Enhance MASSACHUSETTS

This Schedule of Benefits summarizes your coverage under Medicare Enhance ("the Plan") and states the Subscriber cost-sharing amounts that you must pay for Covered Services. However, it is only a summary of your benefits. Please see your *Benefit Handbook* for detailed information on the benefits covered by the Plan and the terms and conditions of coverage.

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPIC) is not responsible for Medicare benefits. Please refer to the Medicare handbook *Medicare & You* or contact the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE (1-800-633-4227)** or www.medicare.gov for information on your Medicare benefits.

Section 1: Subscriber Cost Sharing (What You Pay)

Subscribers are required to share the cost of the benefits provided under the Plan. Please see the tables below for a detailed list of the cost sharing that applies to your Employer Group's plan.

A Copayment is a dollar amount that is payable by the Subscriber for certain Covered Services. The Copayment is due at the time services are rendered or when billed by the Provider. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

Payment Maximum: The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost-sharing amounts that apply under your Plan. If your Plan provides coverage for a service that is not covered by Medicare, the Plan will pay all charges up to the Payment Maximum minus the applicable cost sharing.

Section 2: Preventive Care Services

Medicare covers a number of preventive care services at no cost to Subscribers. The Plan will pay the Medicare Deductible and Coinsurance amounts, if any, for Medicare-covered preventive care services.

Medicare coverage includes a one-time "Welcome to Medicare" preventive visit received within the first 12 months a beneficiary is covered by Medicare Part B. HPIC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly "Wellness" visit. Your first yearly "Wellness" visit must occur 12 months after your Part B enrollment or your "Welcome to Medicare" preventive visit.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings; (5) Bone mass measurements; (6) Glaucoma tests; (7) Medical nutrition therapy services; (8) Counseling to prevent tobacco use & tobacco-caused disease; (9) Colorectal cancer screenings, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema; and (10) Immunizations for flu, pneumococcal shots and hepatitis B shots.

The Plan will also provide coverage, less any payments by Medicare, for the following preventive care services: annual routine physical exams, annual routine eye exams, and annual routine hearing exams. Please refer to Section III.D.2. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan.

Section 3: Emergency Coverage Outside of the United States

Your Plan provides limited emergency coverage for Subscribers traveling outside of the United States. Please refer to Section III.D.3. of your Benefit Handbook for details of your coverage.

Section 4: Inpatient Services Covered by Medicare

Benefit Period: The way that Original Medicare measures a Subscriber's use of Hospital and Skilled Nursing Facility services. A Medicare Benefit Period begins the first day of a Medicare-covered stay at an inpatient Hospital or Skilled Nursing Facility. It ends when you have not received any inpatient Hospital care or Skilled Nursing Facility care for 60 days in a row. If you go into a Hospital or a Skilled Nursing Facility after one Benefit Period has ended, a new Benefit Period begins. Medicare puts no limit on the number of Benefit Periods covered by Medicare during your lifetime.

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Hospital Care (including acute, nonmedical health care institutions, psychiatric and rehabilitation hospitalization)			
First 60 days of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
61st through 90th day of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
91st day and after of a Benefit Period – up to 60 Lifetime Reserve Days (if any)	Covered less Lifetime Reserve Days Daily Coinsurance	Medicare Lifetime Reserve Days Daily Coinsurance	No charge
Non-Medicare Covered Services			
After your 60 Lifetime Reserve Days are exhausted Note: Additional coverage may be available for mental health and substance use disorder treatment. Please see section 6 of this Schedule of Benefits for details.	Nothing	All charges	No charge
Skilled Nursing Facility Care (SNF)			
First 20 days of a Benefit Period	Medicare allowable amount	Nothing	No charge
21st through 100th day of a Benefit Period	Medicare allowable amount minus SNF Daily Coinsurance	The Medicare SNF Daily Coinsurance	No charge

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Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Skilled Nursing Facility Care (SNF) (Continued)			
101st day and after of a Benefit Period	Nothing	Nothing	All charges
Physicians and Other Health Professionals (inpatient services)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Human Organ Transplants (including bone marrow transplants)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Blood Transfusions			
First three pints per calendar year	Nothing	Medicare Blood Deductible	No charge
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Section 5: Outpatient Services Covered by Medicare

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Acupuncture Treatment			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Administration of Allergy Injections			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Ambulance Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Cardiac Rehabilitation Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

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Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Chiropractic Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Dental Care and Oral Surgery			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Diagnostic Tests and Procedures			
Diagnostic tests and procedures	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Durable Medical Equipment (DME) and Prosthetic Devices			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Emergency Room Care			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$30 Emergency Room Copayment per visit, waived if admitted to a Hospital
Home Health Care			
	Medicare allowable amount	Nothing	No charge
Home Infusion Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Hospice Care (including inpatient Respite Care)			
Additional Hospice benefits may apply. See "Section 6: State Mandated Benefits" below.	100% of the Medicare allowable amount; and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance) Benefits are covered less Medicare Deductible	Medicare Deductible and Hospice Coinsurance	No charge

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Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
House Calls			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$15 Copayment per visit
Kidney Dialysis			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Medical Therapies			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Outpatient Methadone Maintenance			
	Nothing	All charges	No charge
Outpatient Surgery			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Physical, Occupational and Speech Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Physicians and Other Health Professionals (including mental health and substance use disorder treatment)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Podiatrist Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit
Telemedicine Virtual Visits			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Urgent Care Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	\$5 Copayment per visit

Section 6: Additional Covered Services

The plan will cover the benefits in this section when Medicare coverage is not available:

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Applied Behavioral Analysis			
	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
COVID-19			
– Testing, treatment, and vaccines See your Benefit Handbook for details.	Nothing	All charges	No charge
Dental Services Inpatient or Surgical Day Care Oral Surgery			
The removal of 7 or more permanent teeth, removal of one or more impacted teeth, excision of radicular cysts involving the roots of three or more teeth, gingivectomies (including osseous surgery) of two or more gum quadrants. Benefits are only provided for the above procedures when the Subscriber has a serious medical condition that makes it Medically necessary that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease	Nothing	All charges	No charge
Emergency Services received outside of the United States			
Note: See your Benefit Handbook for details.	Nothing	All charges less applicable cost sharing	\$30 Emergency Room Copayment per visit, waived if admitted to a Hospital

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HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Hearing Aids			
– Limited to \$2,000 every 2 calendar years	Nothing	Up to \$2,000 every 2 calendar years. First \$500 every 2 calendar years covered in full, then 80% of cost for amounts between \$501 and \$1,500 every 2 calendar years.	20% Copayment up to benefit limit and all charges in excess of the benefit limit
Hospice Care (including inpatient Respite Care)			
	Nothing	All charges	No charge
Low Protein Foods			
– Up to \$5,000 per calendar year	Nothing	All charges	All charges in excess of \$5,000
Mental Health Care and Substance Use Disorder Treatment Services			
Inpatient Services – Benefits are provided for the same number of days as the coverage provided for a physical illness	Nothing	All charges	No charge
Outpatient Services – Benefits are provided for unlimited visits	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
Detoxification and Psychopharmacological Services, Psychological Testing and Neuropsychological Assessment Services	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
Partial Hospitalization	Nothing	All charges	No charge
Routine Eye Exam			
– Limited to 1 exam per calendar year	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
Routine Hearing Exam			
– Limited to 1 exam per calendar year	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
Routine Physical Exam			
	Nothing	All charges	No charge
Scalp Hair Prosthetics (Wigs)			
– Up to \$350 per calendar year	Nothing	All charges	All charges in excess of \$350
Special Formulas for Malabsorption			
	Nothing	All charges	No charge

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Speech Language and Hearing Services			
	Nothing	All charges less applicable cost sharing	\$5 Copayment per visit
Telemedicine Virtual Visits			
	Nothing	All charges less applicable cost sharing	No charge

Section 7. What The Plan Does Not Cover

A. No benefits will be provided by the Plan for any of the following:

- Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in the Benefit Handbook, Schedule of Benefits or (if applicable) the Prescription Drug Brochure.
- Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
- Any product or service obtained at an unapproved facility if Medicare requires that the product or service be provided at a Medicare-approved facility. This exclusion applies to liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a Medicare-approved facility.
- Any product or service provided after the date on which your enrollment in the Plan has ended.
- Any charges that exceed the Payment Maximum.
- Any product or services received in a hospital not certified to provide services to Medicare beneficiaries, unless (1) the hospital is outside the United States, (2) the Subscriber's Plan includes benefits for emergency services outside of the United States, and (3) coverage is available under that benefit.
- Any product or service for which no charge would be made in the absence of insurance.

B. Unless covered by Medicare Parts A and B, no Benefits will be provided by the Plan for any of the following:

- Any product or service that is not Medically Necessary.
- Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
- Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
- Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven or Investigational.

- Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
- Custodial Care.
- Recovery programs including rest or domiciliary care, sober houses, transitional support services and therapeutic communities.
- Eyeglasses, contact lenses, fittings or examinations. (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery).
- Refractive eye surgery, including but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Hearing aids unless specifically listed as a Covered Service in the Schedule of Benefits.
- Hearing aid batteries.
- Biofeedback.
- Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Service. Aromatherapy, treatment with crystals and alternative medicine. Any of the following types of programs: health resorts, spas recreational programs, camps, outdoor residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs), massage therapy and myotherapy.
- Routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes. Foot orthotics, except as required for the treatment of severe diabetic foot disease or systemic circulatory diseases.
- Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs.)
- Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare Deductible and Coinsurance amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover additional Dental Services if such coverage is purchased by an Employer Group. If your Employer Group has purchased coverage for additional Inpatient Dental Services or Outpatient Oral Surgery, such coverage will be listed in the Schedule of Benefits.
- Infertility services or any related services, supplies, or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization.
- Any form of Surrogacy or services for a gestational carrier.
- Ambulance services except as specified in the Benefit Handbook. No benefits will be provided for transportation other than by ambulance.
- Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
- Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

- Any product or service related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Deductible and Coinsurance amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
- Drugs or medications that can be self-administered unless (1) the Employer Group has purchased prescription drug coverage on behalf of the Subscriber, and coverage for such drug or medication is provided for in the Prescription Drug Brochure, (2) the drug or medication is covered by Medicare Parts A or B; or (3) coverage for the drug or medication is mandated by Massachusetts law.
- Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
- Planned home births.
- Devices or special equipment needed for sports or occupational purposes.
- Charges for any product or service, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this Benefit Handbook.
- Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.
- Telemedicine services involving e-mail, fax or non-secure texting.
- Any service or supply (with the exception of contact lenses) purchased from the internet.
- Services provided by a doula.

Section 8: Important Notices

Medical Emergency: You are always covered for care you need in a medical emergency within the United States. In the event of a medical emergency, you should go to the nearest emergency facility or call 911 or the local emergency number.

Coverage will be subject to the terms, conditions, exclusions and limitations of Medicare-eligible services and supplies, and is subject to change pursuant to Medicare guidelines.

This Plan is only available to Subscribers enrolled through Employer Groups. Coverage under the Plan is effective on the first day of the month chosen by your Employer and renews each year on your Employer's anniversary date unless terminated in accordance with the terms of the Employer Agreement. Premiums are subject to change as set forth in the Employer Agreement between HPIC and your Employer Group as permitted by law. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan. To be eligible to enroll, or continue enrollment, in the Plan, an individual must be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment at all times.

VisionCare MASSACHUSETTS

Your VisionCare Benefit

Along with other health care benefits covered under the Plan, your coverage also includes an eyewear benefit. With this additional coverage, you are eligible to be reimbursed by the Plan up to the following amounts:

- \$150 per Calendar Year toward the cost of prescription eyeglass lenses/frames and the fitting/purchase of prescription contact lenses.

Where to Purchase Eyewear With Your VisionCare Benefit

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor. Only contact lenses may be purchased from an internet provider. Prescription eyeglass lenses and/or frames purchased from the internet are not eligible for coverage. Simply pay out-of-pocket and submit to the Plan for reimbursement.

How to Receive Reimbursement for the VisionCare Benefit

To receive reimbursement for the VisionCare benefit, follow these simple steps:

1. Complete a member medical reimbursement form. The form is available online at www.harvardpilgrim.org/public/docs/medical-reimbursement-form, or you can call the Member Services Department at **1-888-333-4742** to request a form. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:

HPHC Claims
P.O. Box 699183
Quincy, MA 02269-9183

We will reimburse you for the lesser of (1) the amount of your payment for covered eyeglasses or contact lenses or (2) the VisionCare benefit limits stated in this brochure. Please allow four to six weeks to receive your reimbursement.

You're Also Eligible for Eyewear Discount Programs

As a Member, you are also eligible for certain eyewear discounts. These discounts can be found online at www.harvardpilgrim.org/savings or refer to the Your Member Savings brochure for a description of these discount programs.

Where to Call With Questions

If you have any questions about your VisionCare benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742**. This telephone number is also listed on your ID card. If you are deaf or hard-of-hearing, please call **711** for TTY service. A representative will be happy to assist you.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou pale Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742 (TTY : 711)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu 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).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телефон: 711).

العربية (Arabic)

إنها: إذا كنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) សូមចូលទៅលើខ្លួន: ពើមួយការិយាយភាគខ្លួន, យើងមានសារភាគមួយប៉ុណ្ណោះដូចមានភាគខ្លួន។ ទូរសព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है। जानकारी के लिये फोन करें। 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો। 1-888-333-4742 (TTY: 711)

ລາວ (Lao) ໂປ່ງດາວ: ຖ້າວ່າ ທ່ານໄວ້ລາວ ລາວ, ການບໍລິການຂ່ອງລູ້ອດ້ານພາວ, ໂດຍບໍ່ແຈ້ງຄ່າ, ດັ່ງນີ້ແມ່ນໄດ້ມີຄວາມໃຫ້ທ່ານ. ໂທດ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).



Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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
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