Value Three-Tier

Prescription Drug Brochure

This brochure is a legal document that explains the prescription drug benefits provided by Harvard Pilgrim Health Care, Inc. (HPHC) to Members with plans that include outpatient pharmacy coverage.

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FORM #2447_04

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PRESCRIPTION DRUG COVERAGE

Prescription medications can play an important role in keeping you healthy. Your coverage includes an outpatient prescription drug benefit to help make paying for these medications more affordable. This benefit covers outpatient prescription drugs and some non-prescription drugs and medical supplies.

In this brochure, you'll find information about:

• Our prescription drug benefit	• Where to buy your prescriptions
• General Member Cost Sharing	• Our Mail Service Prescription Drug Program
• Covered and non-covered drugs	• Drug coverage policies

You will find words in this brochure that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this brochure are defined in the Glossary in your Benefit Handbook.

Your benefits are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

Three-Tier Prescription Drug Benefit

We place all covered drugs into one of three levels or "tiers." Each tier has its own Member Cost Sharing, which is listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage (SBC). The three tiers are described below.

Tier 1:

Tier 1 is primarily made up of generic drugs that have been selected by HPHC. These drugs contain the same active ingredients as their brand name counterparts. However, you pay the lowest Member Cost Sharing amount for Tier 1 drugs.

Tier 2:

Tier 2 is primarily made up of preferred brand name drugs for which there are no generic equivalents available. These drugs have been selected because of their overall high value based on a review of the relative safety, effectiveness and cost of the many brand name drugs on the market. Tier 2 may also include some generic drugs for which there are lower cost or over-the-counter alternatives available.

Tier 3:

Tier 3 is primarily made up of specialty drugs and non-preferred brand name drugs. Tier 3 may also include selected generic drugs for which there are lower cost or over-the-counter alternatives available. See below for information about specialty drugs. You pay the highest member Cost Sharing for Tier 3 drugs.

The Prescription Drug List

The Prescription Drug List identifies all outpatient prescription drugs covered by the Plan. To get a copy of the Value Three-Tier Prescription Drug List visit **www.harvardpilgrim.or** and log into **your secure online account** or call the Member Services Department at **1-888-333-4742**.

Member Cost Sharing

This section describes how we administer the different types of Member Cost Sharing under your outpatient prescription drug benefit.

Similar to your medical coverage, Members are required to share the cost of the benefits provided under the Plan.

Your Member Cost Sharing may include a combination of Copayments, Coinsurance or a Deductible. For the Member Cost Sharing amounts that apply to your Plan, please see your outpatient prescription drug flyer and Summary of Benefits and Coverage.

If a Member chooses to receive a lesser quantity of any Schedule II or Schedule III opioid, the Member's full applicable Cost Sharing will apply and no additional financial penalty will be incurred. For a list of opioids, please visit **www.harvardpilgrim.org/r**, choose the Prescription Drug List for your plan and select Look Up Drugs by Category, then choose Category = Analgesics and Class = Analgesics, Miscellaneous.

Discount Rate

In this brochure, we refer to the term "Discount Rate." The Discount Rate is a price for prescription drugs that has been negotiated with participating pharmacies. The Discount Rate is the basis for calculating your Member Cost Sharing.

Note: The Discount Rate is not a fixed discount. It may be modified as market conditions change. Our cost for covered drugs is generally lower than the Discount Rate.

How the Discount Rate Benefits Members

The Discount Rate is usually lower than the retail price pharmacies charge for drugs. If a participating pharmacy's retail price is less than the Discount rate, your Member Cost Sharing is always based on the lower amount.

Copayments

Some plans provide prescription drug coverage with Copayments. Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Different Copayment amounts usually apply to each of the drug tiers.

What You Pay

Copayments are calculated in two ways, depending on whether you use a participating or non-participating pharmacy:

Participating Pharmacy

If you buy your prescriptions at a participating pharmacy, you pay the lower of the Copayment, the Discount Rate, or the pharmacy's retail price for the drug.

Non-Participating Pharmacy

If you buy your prescriptions at a non-participating pharmacy, you pay the lower of the Copayment or the pharmacy's retail price for the drug.

Please see "Buying Prescriptions" for more information on participating and non-participating pharmacies.

What the Copayment Covers

Each Copayment covers up to a 30-day supply for each prescription or refill, except where limited by us. If your physician prescribes less than a 30-day supply of a medication, each Copayment covers the amount prescribed. We may limit the quantity of a drug available per 30-day period or per Copayment.

Coinsurance

Some plans provide prescription drug coverage with Coinsurance. With Coinsurance, you pay percentage payments for a drug, instead of fixed dollar amounts.

What You Pay

Coinsurance is calculated in two ways, depending on whether you use a participating or non-participating pharmacy.

Participating Pharmacy
If you buy your prescriptions at a participating pharmacy, your Coinsurance payment is calculated using the lower of the Discount Rate or the pharmacy's retail price for the drug.
Non-Participating Pharmacy
If you buy your prescriptions at a non-participating pharmacy, your Coinsurance payment is calculated using the pharmacy's retail price for the drug.

The Coinsurance percentage is multiplied by the Discount Rate or the pharmacy's retail price, as applicable, to arrive at your out-of-pocket Coinsurance payment. Coinsurance is calculated the day the pharmacy fills the prescription and the Coinsurance is paid to the pharmacy at the time of purchase.

✔ FOR EXAMPLE: If the participating pharmacy's retail price is $150 but the Discount Rate is $100, your Coinsurance amount is based on the Discount Rate of $100. If your Coinsurance is 20%, your Member Cost Sharing will be $20.

Some plans include a minimum or maximum Coinsurance amount, or both. If your Plan includes a per prescription minimum amount, you always pay at least that minimum, unless the Discount Rate or the pharmacy's retail price for the drug is less than the minimum. In that case, at the participating pharmacy you pay the lower of (1) the minimum Coinsurance amount, (2) the Discount Rate or (3) the pharmacy's retail price for the drug. At a non-participating pharmacy you pay the lower of (1) the minimum Coinsurance amount or (2) the pharmacy's retail price for the drug. If your Plan includes a per prescription maximum amount, your per prescription Coinsurance payment is limited to that maximum.

Please see "Buying Prescriptions" for more information on participating and non-participating pharmacies.

Deductibles

Your Plan may include a Deductible.

A Deductible is a specific dollar amount that you pay each Plan Year or Calendar Year for certain covered services before any coverage is available for those services. If a Deductible applies to your coverage, you must first pay the Deductible amount for the purchase of prescription drugs before any coverage for drugs begins for the Plan Year or Calendar Year.

Please see your outpatient prescription drug flyer or Summary of Benefits and Coverage to see if a Deductible applies to your Plan.

What You Pay

Participating Pharmacy
When you use a participating pharmacy, you pay the lower of the Discount Rate or the pharmacy's retail price for prescriptions until the Deductible is met.
Non-Participating Pharmacy
When you use a non-participating pharmacy, you pay the pharmacy's retail price for prescriptions until the Deductible is met.

If the Discount Rate or retail price for a prescription, as applicable, exceeds the balance remaining on the Deductible for the Plan Year or Calendar Year, you are required to pay the balance of the Deductible and the applicable Copayment. If Coinsurance applies, you are required to pay the applicable Coinsurance percentage on any amount exceeding the Deductible. You are never obligated to pay any combination of Copayments, Coinsurance or Deductible amounts that exceed the lower of the Discount Rate or the pharmacy's retail price for the drug.

The Deductible amount is applied the day the pharmacy fills the prescription and is paid to the pharmacy at the time of purchase.

Where the Deductible Applies

The Deductible may apply to drugs in any Tier. Once you have met your Deductible for the Plan Year or Calendar Year, drugs are covered for the rest of the Plan Year or Calendar Year, subject to the applicable Copayment or Coinsurance.

✔ FOR EXAMPLE: If your Plan has a $100 Deductible and you have a claim with a discount rate of $200, you will be responsible for the first $100 to satisfy your Deductible requirement before we begin to pay benefits.

Your Deductible may not apply to certain medications used for preventive care. These medications have been selected by the Plan because they are often used to lower the risk of illness. In some cases these medications are prescribed for people who have developed risk factors for an illness that has not yet manifested itself. In others it may be to prevent the recurrence of an illness from which the Member has recovered. Please see your ID card to determine if you have this coverage. Your ID card will include the words "Preventive Drug Benefit" if you have this coverage.

The preventive medications described above are separate from the preventive care services, including drugs, listed in your Schedule of Benefits, for which no Member Cost Sharing applies.

If your Plan exempts preventive drugs from the Deductible and your health care provider prescribes one of the designated preventive medications, the Deductible will not apply to that prescription. However, you will be required to pay the applicable Copayment or Coinsurance amount for the drug. Since no Deductible applies to preventive medications, expenses you incur for such drugs do not apply to your In-Network Deductible.

The Plan may change the listing of designated preventive medications from time to time. To find out if your medication is one of the designated preventive medications, visit **www.harvardpilgrim.or** and log into **your secure online account**.

Out-of-Pocket Maximum

Your Plan may provide prescription drug coverage with an Out-of-Pocket Maximum. Your Out-of-Pocket Maximum may apply to both medical and prescription Member Cost Sharing. The Out-of-Pocket Maximum is the total amount you are required to pay in Member Cost Sharing. If you have a combined medical and prescription Out-of-Pocket Maximum it will be stated on your Schedule of Benefits.

Participating pharmacies will not charge you Member Cost Sharing once you have reached your Out-of-Pocket Maximum.

What is Covered

Your prescription drug benefit covers select Medically Necessary drugs that require a prescription by law, except drugs we exclude or limit. Your benefit also covers the non-prescription items listed below when you have a prescription. All covered drugs are subject to the applicable Member Cost Sharing.

Your Plan covers the following prescription and non-prescription items:

Covered Prescription Drugs	**Covered Non-Prescription Items**
• FDA approved prescription drugs prescribed by a physician and listed as covered in the Prescription Drug List • Needles and syringes needed to administer covered drugs • FDA approved contraceptive drugs and devices* • Prenatal vitamins • FDA approved hormone replacement therapy (HRT) • Off-label uses of FDA approved drugs, including drugs for the treatment of cancer and HIV/AIDS • Compounded prescriptions are covered if: (1) the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and (3) one or more agents within the compound is FDA approved and requires a prescription	• Insulin • Oral agents for controlling blood sugar • Lancets • Blood glucose testing strips • Urine diabetic testing strips • Ketone diabetic testing strips • Certain over-the-counter drugs that are an alternative to a prescription drug **Please Note:** If you are a Medicare member, the items listed above may be covered by your Medicare Part B coverage.

Please Note: No Member Cost Sharing applies to certain preventive care services, including FDA approved contraceptive drugs and devices, oral fluoride for children up to age five, and folic acid for women planning or capable of pregnancy. A Member may receive a 12 month supply of an FDA approved prescription contraceptive after a 3 month trial of the same prescription per Plan Year or Calendar Year in accordance with state law. Please go to **www.harvardpilgrim.org** to see a complete list of covered preventive services.

*A qualified religious employer may exclude coverage for contraceptive drugs and devices. Please see your Schedule of Benefits to determine whether these items are excluded under your Plan.

BUYING PRESCRIPTIONS

Participating Pharmacies

It's easier and often less expensive to fill prescriptions at a participating pharmacy whenever possible. If you use a participating pharmacy, you only have to show your ID card and pay the applicable Member Cost Sharing amount. If you do not use a participating pharmacy, you must pay the retail price for the medication and submit a claim for reimbursement.

There are over 67,000 participating pharmacies in the United States, including:

• CVS/pharmacy	• Target Pharmacy
• Kmart Pharmacy	• Walgreens
• Rite Aid	• Walmart
• Stop & Shop	• Many independent drug stores

You can get more information on participating pharmacies by visiting our website at **www.harvardpilgrim.org/rx** or by calling our Member Services Department at **1-888-333-4742**.

The Specialty Pharmacy Program

We have designated pharmacies that you must use to obtain certain specialty drugs. These include drugs for the treatment of infertility, hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. To find out if your medication needs to be obtained at a specialty pharmacy, visit **www.harvardpilgrim.org** and log into **your secure online account**.

Our specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give you instructions for the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Your Member Cost Sharing at the specialty pharmacies is the same as at other participating pharmacies. The specialty pharmacies are not part of the Mail Service Prescription Drug Program available for non-specialty maintenance medications.

Non-Participating Pharmacies

If you fill a prescription for a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and submit a claim for reimbursement. The reimbursement procedures for pharmacy items are explained in your Benefit Handbook. Reimbursement for drugs purchased at non-participating pharmacies will be paid minus your applicable Member Cost Sharing. Payment will be limited to the Allowed Amount for the drug.

In the case of HMO coverage plans, no benefits are provided for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.

90–Day Prescription Drug Benefit at a Pharmacy

You may purchase up to a 90–day supply of maintenance medications from a participating pharmacy. When you obtain a 90–day prescription you will pay the equivalent of three monthly Member Cost Sharing payments. Although most maintenance medications are available for a 90–day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90–day supply.

Mail Service Prescription Drug Program

We provide a Mail Service Prescription Drug Program for Members who prefer the convenience of receiving their prescriptions through the mail. You may purchase up to a 90-day supply of maintenance medications through the Mail Service Program. In addition to saving a trip to the pharmacy, some plans provide lower Member Cost Sharing amounts for drugs purchased through the Mail Service program.

Although most maintenance medications are available from the Mail Service Program, we may exclude drugs from the program for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available through the Mail Service Program.

For more information about the Plan's Mail Service Prescription Drug Program, please call **1-855-258-1561 (TTY 711)**.

What is Not Covered or has Limited Coverage

There are a number of prescription drugs that are not covered, are subject to quantity limits or require Prior Authorization.

We cover only drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy. Drugs that are not covered include drugs that are not listed in the Prescription Drug List or are listed as non-formulary.

We limit the coverage of specific drugs for reasons of cost and to assure their safe and effective use. Limitations may be placed on the quantity of certain drugs we cover.

We require Prior Authorization to evaluate whether certain drugs are Medically Necessary. Prior Authorization is based on clinical criteria and may include: (1) an evaluation of whether a drug is clinically appropriate for the medical condition for which it has been prescribed; or (2) whether "step therapy" will be required. Drugs subject to step therapy are only covered if a Member has either tried another drug to treat a specific condition or obtained Prior Authorization to be exempted from that requirement. Members or their practitioners may obtain a copy of our clinical review criteria for a drug for which coverage is requested by calling **1-888-888-4742 ext. 31786**.

Drugs that are covered, subject to quantity limits, or require Prior Authorization are listed in the Prescription Drug List. We may add to the list of drugs for which Prior Authorization is required or for which coverage is excluded or limited at any time. You may view the most current copy of this list by visiting **www.harvardpilgrim.org** and logging into **your secure online account**. You may also request a copy of this list by calling the Member Services Department at **1-888-333-4742**.

Exclusions from Coverage

No coverage is provided under this prescription drug brochure for the following:

- Drugs not listed in the Prescription Drug List.
- Drugs listed as non-formulary in the Prescription Drug List.
- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy.
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.)
- Non-prescription items, other than those specifically listed under "What is Covered."

- Drugs that have not been approved by the FDA. (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation.)
- Drugs prescribed as part of a course of treatment that we do not cover.
- Drugs provided to you anywhere other than an outpatient pharmacy. (See your Benefit Handbook for an explanation of the limited coverage available for medications received from physicians and other non-pharmacy providers.)
- Drugs that must be obtained through the Specialty Pharmacy Program if not purchased from one of the program's specially designated pharmacies.
- In the case of HMO coverage plans, no benefits are provided for medications prescribed by providers who are not authorized to do so by us or for prescriptions obtained at a non-participating pharmacy, except in the event of unforeseen illness or injury.
- Any sales tax or governmental assessment on pharmacy items.
- Compounded prescriptions unless: (1) the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and (3) one or more agents within the compound is FDA approved and requires a prescription.

Prior Authorization

Certain drugs require Prior Authorization for coverage under the Plan. These include compounded drugs for Members over the age of 18. Your prescribing provider may request Prior Authorization by completing the form found online at **www.harvardpilgrim.org/pharmacycriteria** and faxing it to OptumRx at **1-800-527-0531**. If you have any questions regarding this process, please contact OptumRx Customer Service at **1-855-258-1561**.

Exception Process

Your Plan has an exception process you may use to ask us to provide coverage for non-formulary drugs or drugs that are limited by the Plan. Drugs are excluded from coverage if they are listed as non-formulary or not listed in the Prescription Drug List except when deemed Medically Necessary under this exception process.

If you have a High Deductible Health Plan where the Deductible does not apply to certain medications for preventive care, you may use the exception process to request that we waive the Deductible for drugs not identified by HPHC as a preventive drug. Your ID card will include the words "Preventive Drug Benefit" if you have this coverage. Please see the section titled, "Deductibles", above, for more information on the preventive drug benefit.

Medical providers may request an exception on behalf of a Member for coverage of any drug that is non-formulary or limited (or a preventive care drug subject to the deductible) by providing a statement that explains why an exception is Medically Necessary. This should include the reason(s) why the covered drugs on the Prescription Drug List are not as effective as the requested drug. Exceptions may be granted only for clinical reasons. Expedited exception requests can be made if you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug.

Providers may complete the form found online at **www.harvardpilgrim.org/pharmacycriteria** and fax it to OptumRx at **1-800-527-0531**. If you have any questions regarding this process, please contact OptumRx Customer Service at **1-855-258-1561**.

We will act on a request for an exception within 48 hours of receiving your prescribing provider's statement of the reasons an exception is Medically Necessary. If you request an exception for a Medically Necessary prescription drug that is non-formulary or limited by the Plan and we do

not respond to your request within 48 hours after receiving the clinical rationale from your prescribing provider, your request will be approved. For expedited exception requests, we will notify you of a decision no later than 24 hours after receiving your expedited request.

If a standard or expedited exception request is denied, you may request that the original exception request and denial are reviewed by an independent review organization. A determination will be made within one business day of receipt of the complete information for standard and expedited requests. If we deny your request, we will tell you the reason for the denial and explain the process for requesting an appeal of our decision.

About Your Drug Benefit

Pharmacy and Therapeutics Committee

Our Pharmacy and Therapeutics (P & T) Committee is an advisory group comprised of our clinical staff and of physician specialists, independent physicians, and pharmacy specialists that work together to promote clinically sound, cost effective pharmaceutical care.

The P&T Committee makes recommendations for tier placement of drugs, and limitations on drug coverage, as well as providing guidance on clinical criteria.

Tier Changes

We regularly review and update the Prescription Drug List as new drugs or drug information becomes available. As a result, the tier placement of covered drugs may change at any time. In the event that a drug has been reassigned to a higher tier, we will send notice to Members who have received coverage for the drug and product during the 100-day period prior to the notice date. Such notice will be sent 60 days before the tier change takes effect. You can get an updated Prescription Drug List by visiting **www.harvardpilgrim.org** and logging into **your secure online account**, or by calling the Member Services Department at **1-888-333-4742**.

Deletions from Coverage

We may discontinue coverage of a drug identified on the Prescription Drug List or covered under this Brochure. Generally, such changes will take place annually. In such event, we will send notice to Members who have received coverage for the drug or product during the 12-month period prior to the date of discontinuation. Such notice will be sent at least 60 days before discontinuing coverage for the drug or product unless the FDA has determined the drug or product to be unsafe.

New To Market Drugs

New prescription drugs that are introduced into the market are reviewed by the Plan prior to coverage to ensure that the drug is safe and effective. New to market drugs will be reviewed by Harvard Pilgrim's Pharmacy & Therapeutics Committee or Clinical Pharmacy Specialists within the first six months of their introduction on the market. If the new to market drug is covered by the Plan, Prior Authorization and coverage limitations may apply.

Important Notice

In the event of a Medical Emergency, seek immediate care. You may call **911** or your local emergency number. Please see your Benefit Handbook and Schedules of Benefits for information on your emergency coverage.

Incorporation with Benefit Handbook

This Prescription Drug Brochure incorporates the terms and conditions provided in your plan's Benefit Handbook including, but not limited to, appeals and grievance processes, utilization review procedures and coordination of benefits and subrogation policies.

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 palé 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 quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí 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 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة **العربية**، خَدَمات اَلْمُساعَدة اَللُّغوية مُتوفرة لك مَجانًا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសូមជូនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 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 करे. 1-888-333-4742 (TTY: 711)

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)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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.

(Continued)

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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.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
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