

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

CLEAR CHOICE HMO HSA BRONZE

MAINE

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742 if you are covered under an Employer Group plan or 1-877-907-4742 if you are covered under an individual Member plan.

Comparable Health Care Service Incentive Program: Reduce My Costs Program

You can obtain care for certain covered outpatient health care services and diagnostic tests from participating Plan Providers at a lower cost through Harvard Pilgrim's Reduce My Costs program. If you choose to receive care from one of the low-cost providers, you may be eligible to receive a cash reward (there is no limit to the number of rewards). Reward dollars vary depending on the service and the associated cost savings. The medical services and diagnostic tests must be Covered Benefits within the following categories:

- Physical and occupational therapy services
- Radiology and imaging services
- Laboratory services and x-rays
- Infusion therapy services

To participate, call Harvard Pilgrim's Reduce My Costs Program at the toll-free Reduce My Costs number for all HPHC Members. The toll-free number is **1-855-772-8366**, and you can call whenever your doctor recommends a diagnostic test or procedure. You will be connected to a trained Reduce My Costs nurse. The nurse will compare the cost of health care facilities near your home or work, will inform you if there are any lower-cost Harvard Pilgrim participating providers available in the area, reschedule your appointment and help with any paperwork, and help you find available information about the quality of the health care providers.

For more information about this program, including details about the specific eligible Covered Benefits and incentive awards, please visit: www.harvardpilgrim.org/reducemycosts/maine.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a Physician's office, see

EFFECTIVE DATE: 01/01/2023

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"Physician and Other Professional Office Visits." For services provided in a Hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

General Cost Sharing Features:		Member Cost Sharing:
Coinsurance and Copayments		
		See the benefits table below
Deductible		
		\$6,300 for Individual Coverage per Calendar Year \$12,600 for Family Coverage per Calendar Year – with a \$6,300 embedded individual Deductible per Calendar Year
Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible can be satisfied in one of two ways: a. If a Member of a covered family meets the embedded individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the Family Coverage Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Deductible amount toward the Family Coverage Deductible. An embedded individual Deductible may not be less than the applicable minimum family Deductible, as defined by the Internal Revenue Service. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing		\$7,500 for Individual Coverage per Calendar Year \$15,000 for Family Coverage per Calendar Year – with a \$7,500 embedded individual Out-of-Pocket Maximum per Calendar Year
Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the Family Coverage Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Out-of-Pocket Maximum amount toward the Family Coverage Out-of-Pocket Maximum.		

Benefit	Your Cost Sharing
Acupuncture Treatment for Injury or Illness	
	Deductible, then 50% Coinsurance

Benefit		Your Cost Sharing
Ambulance and Medical Transport		
Emergency ambulance transport		Deductible, then 50% Coinsurance
Non-emergency medical transport		Deductible, then 50% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis		Deductible, then 50% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy		Deductible, then 50% Coinsurance
Radiation therapy		Deductible, then 50% Coinsurance
Chiropractic Care		
		Deductible, then 50% Coinsurance
Clinical Trials		
		Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a Physician's office, see "Physician and Other Professional Office Visits." For inpatient Hospital care, see "Hospital – Inpatient Services."
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Emergency Dental Care (within six months of injury or within six months of the effective date of coverage, whichever is later) Other dental services, including setting a jaw fracture and removing a tumor (but not a root cyst) General anesthesia for dentistry		Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a Physician's office, see "Physician and Other Professional Office Visits." For inpatient Hospital care, see "Hospital – Inpatient Services."
Extraction of teeth impacted in bone (performed in a Physician's office)		Deductible, then 50% Coinsurance
Dialysis		
Dialysis services, including dialysis training		Deductible, then 50% Coinsurance
Durable Medical Equipment		
Durable medical equipment, including orthotic devices as described in the Benefit Handbook		Deductible, then 50% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)		Deductible, then 50% Coinsurance
Oxygen and respiratory equipment		Deductible, then 50% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
– Limited to 40 visits per Calendar Year		Deductible, then 50% Coinsurance
Emergency Room Care		
		Deductible, then 50% Coinsurance

Benefit		Your Cost Sharing
Hearing Aids		
For Members up to age 19: – Limited to 1 hearing aid per hearing impaired ear every 36 months For all other Members: – Limited to \$3,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 50% Coinsurance	
Home Health Care		
Including infusion therapy and nutritional counseling	Deductible, then 50% Coinsurance	
If services include the administration of drugs, please see the benefit for “Medical Drugs” for Member Cost Sharing details.		
Hospice Services		
	Deductible, then 50% Coinsurance	
If inpatient services or respite care are required, please see “Hospital – Inpatient Services” for Member Cost Sharing details.		
Hospital – Inpatient Services		
Acute Hospital care, including bariatric surgery, blood transfusions, infusion therapy, inhalation therapy, organ or tissue transplants and breast reduction surgery and symptomatic varicose vein surgery	Deductible, then 50% Coinsurance	
Inpatient maternity care	Deductible, then 50% Coinsurance	
Inpatient routine nursery care	No charge	
Inpatient rehabilitation – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 50% Coinsurance	
Skilled nursing facility – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 50% Coinsurance	
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)		
Laboratory, including but not limited to human leukocyte antigen testing as described in the Benefit Handbook	Deductible, then 50% Coinsurance	
Genetic testing	Deductible, then 50% Coinsurance	
Radiology	Deductible, then 50% Coinsurance	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 50% Coinsurance	
Other diagnostic services (including allergy testing)	Deductible, then 50% Coinsurance	
Low Protein Foods		
	Deductible, then 50% Coinsurance	

Benefit		Your Cost Sharing
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under “Physician and Other Professional Office Visits” and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under “Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers).”		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs, including infusion therapy, received in a Physician’s office or other outpatient facility	Deductible, then 50% Coinsurance	
Medical drugs, including infusion therapy, received in the home	Deductible, then 50% Coinsurance	
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas		
State mandated formulas	Deductible, then 50% Coinsurance	
Mental Health and Substance Use Disorder Treatment		
Inpatient Services	Deductible, then 50% Coinsurance	
Partial hospitalization services	Deductible, then 50% Coinsurance	
Outpatient group therapy	Deductible, then 50% Coinsurance	
Mental health services in the home	Deductible, then 50% Coinsurance	
Outpatient treatment, including individual therapy, detoxification, and medication management	Deductible, then 50% Coinsurance	
Outpatient methadone maintenance	Deductible, then no charge	
Outpatient psychological testing and neuropsychological assessment	Deductible, then 50% Coinsurance	
Outpatient telemedicine virtual visit services	Deductible, then 50% Coinsurance	
Observation Services		
	Deductible, then 50% Coinsurance	
Ostomy Supplies		
	Deductible, then 50% Coinsurance	
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations, including annual gynecological exams, for preventive care, including immunizations and annual digital rectal exams	No charge	

Benefit	Your Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)	
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at www.harvardpilgrim.org . Please see "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)," for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, Sickness and injury care, including nutritional counseling	Deductible, then 50% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, the application of dressings, inhalation therapy, non-routine foot care, and surgical procedures	Deductible, then 50% Coinsurance
Administration of allergy injections	Deductible, then 50% Coinsurance
Preventive Services and Tests	
	No charge
Under Federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms, pap tests, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services notice by calling the Member Services Department at 1-888-333-4742 if you are covered under an Employer Group plan or 1-877-907-4742 if you are covered under an individual Member plan. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance.	
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge
Prosthetic Devices	
Prosthetic devices (other than arms and legs)	Deductible, then 50% Coinsurance
Prosthetic arms and legs	Deductible, then 50% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation– limited to 36 visits per cardiac episode	Deductible, then 50% Coinsurance

Benefit		Your Cost Sharing
Rehabilitation and Habilitation Services – Outpatient (Continued)		
Pulmonary rehabilitation therapy		Deductible, then 50% Coinsurance
Occupational therapy Rehabilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Habilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined		Deductible, then 50% Coinsurance
Physical therapy Rehabilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Habilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined		Deductible, then 50% Coinsurance
Speech therapy Rehabilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Habilitation Services (including treatment for head injuries) – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined		Deductible, then 50% Coinsurance
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits.		
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy		Deductible, then 50% Coinsurance
Surgery – Outpatient		
		Deductible, then 50% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
		Deductible, then 50% Coinsurance
For inpatient Hospital care, see “Hospital – Inpatient Services” for cost sharing details.		
Urgent Care Services		
Doctor on Demand		Deductible, then no charge
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at www.harvardpilgrim.org .		
Convenience care clinic (retail health clinic)		Deductible, then 50% Coinsurance

Benefit		Your Cost Sharing
Urgent Care Services (Continued)		
Urgent care center		Deductible, then 50% Coinsurance
Hospital urgent care center		Deductible, then 50% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."		
Vision Services		
Urgent eye care		Deductible, then 50% Coinsurance
Routine adult eye examinations – limited to 1 exam per Calendar Year		No charge
Routine pediatric eye examinations – limited to 1 exam per Calendar Year		No charge
Vision hardware for special conditions		Deductible, then 50% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.		
Voluntary Sterilization – in a Physician's Office		
		Deductible, then 50% Coinsurance
Voluntary Termination of Pregnancy		
		Deductible, then 50% Coinsurance

Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 24 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

The Plan will reimburse you for the first \$50 you pay toward covered prescription eyeglass frames and lenses after your medical Deductible is met. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints, scratch proofing and progressive lenses. Coverage is also excluded for deluxe and designer eyeglass frames.

(B) PRESCRIPTION CONTACT LENSES

The Plan will reimburse for the first \$50 you pay toward your first order of covered prescription contact lenses after your medical Deductible is met. Thereafter, the plan will reimburse you 50% of your remaining covered charges. Reimbursement for disposable contact lenses is limited to a 6 month supply.

OUT-OF-POCKET MAXIMUM

All Member Cost Sharing under this benefit applies toward your annual Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the Out-of-Pocket Maximum amount that applies to your plan.

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE 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.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

1. Complete a member reimbursement form. You can obtain this form by visiting our website at www.harvardpilgrim.org or by calling the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an individual Member plan 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 your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an individual Member plan. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies
- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons
- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

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 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 (телетайп: 711).

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

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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 मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

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

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ຄ່າມີພ້ອມໃຫ້ທ່ານ. ໂທ 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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or 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, sex, sexual orientation, or 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

(800) 368-1019, (800) 537-7697 (TTY)

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



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