ID:
DN0000200171_202320
DATE: 01/01/2023

Pediatric Dental Rider - POS

Harvard Pilgrim Health Care, Inc.
(for children up to the age of 19)
MAINE

The pediatric dental rider identifies the covered dental services as described below for dependents up to the age of 19 enrolled in the POS plan (the Plan). Coverage under this rider terminates at the end of the month in which the Dependent reaches the age of 19.

Because this rider is part of your Evidence of Coverage and is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Benefit Handbook* in *Section II: Glossary* or in this rider in *Section 5: Defined Terms for Pediatric Dental Services.*

When we use the words "we," "us," and "our" in this document, we are referring to Harvard Pilgrim Health Care. When we use the words "you" and "your" we are referring to people who are Dependents, as the term is defined in the *Benefit Handbook* in *Section II: Glossary*.

SECTION 1: ACCESSING PEDIATRIC DENTAL SERVICES

In-Network Benefits

These Covered Benefits apply when you choose to obtain Covered Dental Services from an In-Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an Out-of-Network provider. In-Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay an In-Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as In-Network Benefits, you must obtain all Covered Dental Services directly from or through an In-Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to an In-Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* at **1–800–460–0315** to determine which providers participate in the Network. The telephone number for *Customer Service* is also listed on your ID card.

Out-of-Network Benefits

These Covered Benefits apply when you decide to obtain Covered Dental Services from an Out-of-Network Dental Provider, including any Dental Provider outside the country.

You generally are required to pay more for Out-of-Network Benefits than for In-Network Benefits. Out-of-Network Benefits are paid at the 80th percentile of the Out-of-Network Dental Provider's charge up to the Usual, Customary and Reasonable Charge, as defined in this pediatric dental rider. As a result, you may be required to pay an Out-of-Network Dental Provider for a Covered Dental Service any amount he or she charges that is in excess of the Usual, Customary and Reasonable Charge. In addition, when you obtain Covered Dental Services from Out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Covered Dental Services listed in this rider if such Dental Services are Necessary and are provided by or under the direction of a Dental Provider.

Covered Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this rider.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Covered Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Covered Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for all Orthodontic Services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. You or your Dental Provider can request Pre-authorization for these services by contacting us at **1–800–460–0315**. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by us. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

SECTION 2: BENEFITS FOR PEDIATRIC DENTAL SERVICES

Covered Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. The least costly clinically appropriate service. Clinical situations that can be effectively treated by a less costly, clinically appropriate alternative procedure will be covered based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this rider.

Benefits

Dental Services Deductible's are calculated on a Calendar Year basis.

When Benefit limits apply, the limit stated refers to any combination of In-Network Benefits and Out-of-Network Benefits unless otherwise specifically stated

General Cost Sharing Features	In-Network	Out-of-Network
Deductible		
	Please see your medical *Schedule of Benefits*	Please see your medical *Schedule of Benefits*
Out-of-Pocket Maximum		
	Please see your medical *Schedule of Benefits*	Please see your medical *Schedule of Benefits*

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE I SERVICES: ***PREVENTIVE & DIAGNOSTIC BASIC COVERED SERVICES***		
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) – Limited to 1 set every 6 months	No charge	20% Coinsurance
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) – Limited to 1 film every 60 months	No charge	20% Coinsurance
Periodic Oral Evaluation (Check up Exam) – Limited to 1 every 6 months	No charge	20% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE I SERVICES: ***PREVENTIVE & DIAGNOSTIC BASIC COVERED SERVICES*** **(Continued)**		
Preventive Services		
Dental Prophylaxis (Cleanings) – Limited to 1 every 6 months	No charge	20% Coinsurance
Fluoride Treatments – Limited to 2 treatments per 12 months.	No charge	20% Coinsurance
Sealants (Protective Coating) – Limited to one sealant per tooth every 36 months.	No charge	20% Coinsurance
Space Maintainers	No charge	20% Coinsurance
TYPE II SERVICES: ***MINOR RESTORATIVE COVERED SERVICES***		
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery		
Amalgam Restorations (Silver Fillings)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth – Limited to once per tooth per lifetime.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 24 months.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following completion of active periodontal therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES* (Continued)		
Simple Extractions (Simple tooth removal)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Oral Surgery, including Surgical Extraction	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) General anesthesia is covered when clinically necessary.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
TYPE III SERVICES: *MAJOR RESTORATIVE SERVICES*		
Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars – Limited to once per tooth per lifetime.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Endodontic Surgery	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Fixed Prosthetics (Bridges) – Limited to once per tooth per 60 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Occlusal guards for Members age 13 and older – Limited to one guard every 12 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Periodontal Surgery (Gum Surgery) – Limited to one quadrant or site per 36 months per surgical area.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Removable Prosthetics (Full or partial dentures) – Limited to one per 60 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE III SERVICES: *MAJOR RESTORATIVE SERVICES* (Continued)		
Implants		
Implant Placement – Limited to once per 60 months. Implant Supported Prosthetics – Limited to once per 60 months. Implant Maintenance Procedures – Limited to once per 60 months. Repair Implant Supported Prosthesis by Report – Limited to once per 60 months. Repair Implant Abutment by Support – Limited to once per 60 months. Radiographic/Surgical Implant Index by Report – Limited to once per 60 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
TYPE IV SERVICES: *ORTHODONTIA*		
Orthodontic Services Covered Benefits will be paid in equal installments over the course of the entire orthodontic treatment plan as agreed upon between you and your Dental Provider, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.		
Benefits for comprehensive orthodontic treatment are approved, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE IV SERVICES: *ORTHODONTIA* (Continued)		
(TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. **Note:** All orthodontic treatment must be prior authorized.		

SECTION 3: PEDIATRIC DENTAL EXCLUSIONS

Except as may be specifically provided in this rider under *Section 2: Benefits for Covered Dental Services*, no benefits are provided under this rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this rider in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental, Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Covered Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental

Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided through this rider to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Dependent or who is a member of a Dependent's family, including spouse, brother, sister, parent or child.
18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

SECTION 4: APPEALS AND GRIEVANCES

Appeals

If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member's representative or a provider acting on a Member's behalf and must be received within 180 days of the initial denial. Our staff is available to assist you in filing an appeal. If you'd like assistance, please call *Customer Service* at **1–800–460–0315**.

To initiate your appeal, you or your representative should write a letter to us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision. Please send your request to the following address:

Harvard Pilgrim Health Care
Attention: Appeals
P.O. Box 30569
Salt Lake City, UT 84130–0569

You may also contact us at **1–800–460–0315** to initiate your appeal.

Grievances

If you have a complaint about your care under the Plan or about our service, we want to know about it. For all grievances, please call or write to us at:

Harvard Pilgrim Health Care
Attention: Grievances
P.O. Box 30569
Salt Lake City, UT 84130–0569

For additional information on the Appeals and Grievance process, please refer to your Benefit Handbook.

Telephone: 1–800–460–0315

SECTION 5: CLAIMS FOR PEDIATRIC DENTAL SERVICES

When obtaining Dental Services from an Out–of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities listed below apply to Covered Dental Services provided under this rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for a claim for reimbursement (proof of loss) to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Dependent's name and address
- Dependent's identification number
- The name and address of the provider of the service(s)
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began

- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you can request one be mailed to you by calling *Customer Service* at **1–800–460–0315**. This number is also listed on your ID Card. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Please mail your request for reimbursement to the following address:

Claims – Harvard Pilgrim Health Care
P.O. Box 30567
Salt Lake City, UT 84130–0567

Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

SECTION 6: DEFINED TERMS FOR PEDIATRIC DENTAL SERVICES

The following definitions are in addition to those listed in *Section II: Glossary* of the *Benefit Handbook*:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this rider.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Dependent up to the age of 19 while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dental Services Deductible - the amount a Dependent up to the age of 19 must pay for Covered Dental Services in a Calendar Year before we will begin paying for Covered Benefits in that year.

Dental Services Out-of-Pocket Maximum – a limit on the amount of Copayments, Coinsurance and Deductible's that you must pay for Covered Benefits in a Calendar Year

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For In-Network Benefits, when Covered Dental Services are received from In-Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Eligible Dental Expenses are the lesser of the Usual and Customary fees, as defined below or the billed charges.

Necessary - Dental Services and supplies under this rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Dependent up to age 19.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Dependent or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.
        - Provided in a clinically controlled research setting.
        - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this rider. The definition of Necessary used in this rider relates only to Benefits under this rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual, Customary and Reasonable Charge - Usual, Customary and Reasonable Charge is the maximum amount that we will pay for services from Dental Providers. The Usual, Customary and Reasonable Charge is calculated using the 80th percentile of provider reimbursement for services in the same geographic area under the FAIR Health database.

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 اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជួនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, បើសេវាកម្មបកប្រែ 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 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, 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)

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