Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

Standard Low Silver HSA - Flex
MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts that 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.

Clinical Review Criteria

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 clinical review criteria on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742**.

Flex Providers This Plan includes Flex Providers. A Flex Provider is a Plan Provider who provides certain outpatient services with lower Member Cost Sharing. When you receive these Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not listed as a Flex Provider. The table below identifies the outpatient services which may be obtained from a Flex Provider and the applicable Member Cost Sharing.

The Plan's Provider Directory lists all Plan Providers including those providers listed as a Flex Provider. You can access the Provider Directory at **www.harvardpilgrim.org**. You may also obtain a paper copy free of charge by calling the Member Services Department at **1-888-333-4742**.

Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment known as "Level 1," and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to most outpatient specialty care.

If a provider is categorized as both a Level 1 provider and a Level 2 provider, Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for a Level 1 Copayment.

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the

Member Services Department at **1-877-907-4742**. 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 "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."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
Applies to all services except where specifically noted below	$2,000 for Individual Coverage per Plan Year $4,000 for Family Coverage per Plan Year
Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The Individual Deductible does not apply. 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	$6,850 for Individual Coverage per Plan Year $13,700 for Family Coverage per Plan Year
Important Notice: If you are a Member with Family Coverage, the Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year. b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more than the individual embedded Out-of-Pocket Maximum amount toward the family Out-of-Pocket Maximum.	

Benefit	Member Cost Sharing:
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Plan Year	Deductible, then $50 Copayment per visit
Ambulance Transport	
Emergency ambulance transport	Deductible, then no charge
Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Deductible, then Level 1: $30 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then no charge

Benefit	Member Cost Sharing:
Dental Services (Continued)	
If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.	
Dialysis	
	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	Deductible, then no charge
Oxygen and respiratory equipment	Deductible, then no charge
Early Intervention Services	
	Deductible, then no charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Room Care	
	Deductible, then $300 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
Hearing Aids (for Members up to the age of 22)	
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance
Home Health Care	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Deductible, then $750 Copayment per admission
Inpatient maternity care	Deductible, then $750 Copayment per admission
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then $750 Copayment per admission
Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then $750 Copayment per admission
Infertility Services and Treatments (see the Benefit Handbook for details)	
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	**Flex Providers** Deductible, then $20 Copayment per visit **Other Plan Providers** Deductible, then $60 Copayment per visit

Benefit	Member Cost Sharing:
Laboratory, Radiology and Other Diagnostic Services (Continued)	
Genetic testing	Deductible, then $60 Copayment per visit
Radiology	Deductible, then $75 Copayment per visit
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a physician's office or non-hospital affiliated facility** Deductible, then $200 Copayment per procedure **In a hospital or hospital affiliated facility** Deductible, then $500 Copayment per procedure
Other diagnostic services	Deductible, then $60 Copayment per visit
Low Protein Foods	
	Deductible, then 20% Coinsurance
Maternity Care - Outpatient	
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge
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 services is listed under "Laboratory, Radiology and Other Diagnostic Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge
Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. Your Member Cost Sharing for outpatient prescription drugs is listed under the Prescription Drug section in this Schedule of Benefits.	
Medical Formulas	
	Deductible, then no charge
Mental Health and Substance Use Disorder Treatment	
Inpatient services	Deductible, then $750 Copayment per admission
Intermediate care services	Deductible, then no charge
Outpatient group therapy	Deductible, then $10 Copayment per visit
Outpatient treatment, including individual therapy, detoxification and medication management	Deductible, then Level 1: $30 Copayment per visit
Outpatient methadone maintenance	Deductible, then no charge
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge
Observation Services	
	Deductible, then $750 Copayment per observation stay
Ostomy Supplies	
	Deductible, then 20% Coinsurance

Benefit	Member Cost Sharing:
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
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" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations and sickness and injury care	Deductible, then Level 1: $30 Copayment per visit Deductible, then Level 2: $60 Copayment per visit
Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment level applies. 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."	
Office based treatments and procedures, including, but not limited to: administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures	Deductible, then no charge
Administration of allergy injections	Deductible, then no charge
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, 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 **1-877-907-4742**. 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	
	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation	Deductible, then Level 2: $60 Copayment per visit
Pulmonary rehabilitation therapy	Deductible, then Level 2: $60 Copayment per visit

Benefit	Member Cost Sharing:
Rehabilitation and Habilitation Services – Outpatient (Continued)	
Speech-language and hearing services	**In a physician's office or non-hospital affiliated facility** Deductible, then Level 1: $30 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then Level 2: $60 Copayment per visit
Rehabilitation Services: – Physical and occupational therapies combined up to 60 visits per Plan Year Habilitation Services: – Physical and occupational therapies combined up to 60 visits per Plan Year	**In a physician's office or non-hospital affiliated facility** Deductible, then Level 1: $30 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then Level 2: $60 Copayment per visit
Outpatient physical and occupational therapy is not subject to the limits listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	**Flex Providers** Deductible, then $250 Copayment per visit **Other Plan Providers** Deductible, then $500 Copayment per visit
Spinal Manipulative Therapy (including care by a chiropractor)	
	Deductible, then $50 Copayment per visit
Surgery – Outpatient	
	Flex Providers Deductible, then $250 Copayment per visit **Other Plan Providers** Deductible, then $500 Copayment per visit
Telemedicine Virtual Visit Services - Outpatient	
	Deductible, then Level 1: $30 Copayment per visit Deductible, then Level 2: $60 Copayment per visit
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.	
Urgent Care Services	
Doctors On Demand	Deductible, then no charge
Important Note: Doctors On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctors On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.	
Convenience care clinic	Deductible, then Level 1: $30 Copayment per visit
Urgent care center	Deductible, then Level 2: $60 Copayment per visit
Hospital urgent care center	Deductible, then Level 2: $60 Copayment per visit
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."	
Vision Services	
Routine eye examinations — limited to 1 exam per Plan Year	Deductible, then Level 1: $30 Copayment per visit
Vision hardware for special conditions	Deductible, then no charge
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.	

Benefit	Member Cost Sharing:
Voluntary Sterilization in a Physician's Office	
	Deductible, then no charge
Voluntary Termination of Pregnancy	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
Wellness Reimbursement Benefits (see the Benefit Handbook for details)	
Fitness – Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center **or** costs paid toward a fitness tracker as follows: – One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year **or** is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.* – A second Member is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.	No charge
*If a Member receives reimbursement for one month of individual or family fitness membership which is less than $150, then the difference may be applied toward the cost of the Member's fitness tracker. If the cost of one month of individual or family fitness membership is greater than $150, then the 1 month is covered in full and there is no further coverage available for that Member.	
Weight management programs – Coverage provided for 3 months of membership at Weight Watchers traditional meetings or Weight Watchers at Work programs per calendar year.	No charge
Wigs and Scalp Hair Prostheses	
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance

Value Outpatient Prescription Drug Coverage

Benefit:	Member Cost Sharing:
Your pharmacy Copayments for up to a 30-day supply are:	
Please Note: Your Plan includes the Preventive Drug Benefit. Your Deductible will not apply to certain medications used for preventive care. However, you are still subject to any applicable Copayment or Coinsurance as described in the tables below.	
Tier 1:	Deductible, then $30 Copayment per prescription or prescription refill
Tier 2:	Deductible, then $60 Copayment per prescription or prescription refill
Tier 3:	Deductible, then $105 Copayment per prescription or prescription refill
Your pharmacy Copayments for up to a 90–day supply of maintenance medications at a retail pharmacy are:	
Tier 1:	Deductible, then $90 Cpayment per prescription or prescription refill
Tier 2:	Deductible, then $180 Copayment per prescription or prescription refill
Tier 3:	Deductible, then $315 Copayment per prescription or prescription refill
Harvard Pilgrim's mail service prescription drug program.	
You may purchase a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program. Your mail service Copayments for a 90-day supply are:	
Tier 1:	Deductible, then $60 Copayment per prescription or prescription refill
Tier 2:	Deductible, then $120 Copayment per prescription or prescription refill
Tier 3:	Deductible, then $315 Copayment per prescription or prescription refill
A summary of your cost sharing amounts for your prescription drug coverage is also listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. To obtain coverage for your prescription drugs bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the appropriate amount. Please refer to your Prescription Drug Brochure for detailed information about your coverage.	

Pediatric VisionCare

Dependents under 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 12 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. 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 you for the purchase of your first order of prescription contact lenses up to the following amounts:

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

In addition to the Covered Benefits described above, Dependents under the age of 19 are also eligible for the following:

(C) MEDICALLY NECESSARY CONTACT LENSES

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear.

The Plan will reimburse you for the first $50 you pay toward Medically Necessary contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

(D) LOW VISION SERVICES

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. Covered low vision services will include (1) one comprehensive low vision evaluation every 5 years; (2) Medically Necessary visual aids such as high-power eyeglasses, magnifiers and telescopes; and (3) follow-up examinations as Medically Necessary.

See "Physician and Other Professional Office Visits" for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you for the first $50 you pay toward

visual aids as described above. Thereafter, the Plan will reimburse you 50% of your remaining covered charges for visual aids.

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

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

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 **1-877-907-4742** 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 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 **1-877-907-4742**. 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 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) ប្រសូមជូនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, 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 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 Connecticut, 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. 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
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 Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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