Schedule of Benefits

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION
MEDICARE ENHANCE

Services are covered only when Medically Necessary. Please see your Benefit Handbook for the details of your coverage.

INTRODUCTION

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

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPHC) is not responsible for Medicare Benefits. Please refer to the Medicare program handbook, *Medicare and You* or contact the Centers for Medicare and Medicaid Services (CMS), for information on your Medicare benefits. You may call CMS for information on Medicare Parts A and B at: 1-800-MEDICARE (1-800-633-4227).

SECTION 1: SUBSCRIBER COST SHARING (WHAT YOU PAY)

Subscribers are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost-sharing amounts under your plan.

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

If your Plan provides coverage for a service that is not covered by Medicare, the Plan will pay all charges up to the Payment Maximum minus the applicable Copayment.

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.
** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 2: PREVENTIVE CARE SERVICES

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

Medicare coverage includes a one-time "Welcome to Medicare" physical examination received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly physical exam, known as a "Wellness" visit. The first yearly physical exam must take place at least 12 months after the "Welcome to Medicare" physical examination, if a beneficiary has had one.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings and (5) bone mass measurements; (6) glaucoma testing; (7) medical nutrition therapy; (8) counseling to stop smoking; (9) colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and (10) immunizations for flu, pneumonia and hepatitis B. Coverage for mammograms includes a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

Please refer to Section III. D. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan. Please consult with your doctor and refer to the Medicare publication, *Medicare and You*, for additional information on preventive care services that may benefit you.

SECTION 3: COVERAGE OUTSIDE OF THE UNITED STATES

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

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 4: INPATIENT SERVICES

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Hospital Care (including acute, rehabilitation and psychiatric hospitalizations)				
Days 1-60 in Benefit Period	All but Medicare Deductible amount	Medicare Deductible amount	Nothing	III.B.1
Days 61+	All but Medicare Coinsurance amount	Medicare Coinsurance amounts	Nothing	
Up to 60 Lifetime Reserve Days (if any)	All but Reserve Days Daily Coinsurance amount	Medicare Lifetime Reserve Days Daily Coinsurance amounts	Nothing	
After your 60 Lifetime Reserve Days are exhausted **Note**: Additional coverage may be available for mental health and substance use disorder treatment Please see Section 6 of this Schedule of Benefits.	Nothing	All charges to the extent Medically Necessary	Nothing	
Skilled Nursing Facility Care (SNF)				
Days 1-20	Medicare allowable amount	Nothing	Nothing	III.B.1.b
Days 21-100	Medicare allowable amount minus SNF Daily Coinsurance amount	The SNF Daily Coinsurance amounts	Nothing	
Days 100 +	Nothing	Nothing	All Charges	
Religious Nonmedical Health Care Institutions	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.1.c
Physicians and Other Professionals (inpatient services only)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.1
Blood Transfusions				XI
First 3 pints of blood per calendar year	Nothing	Medicare Blood Deductible	Nothing	
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	
Human Organ Transplants (Including bone marrow transplants)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.1.a III.C.4

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 5: OUTPATIENT SERVICES

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Emergency Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less Emergency room Copayment per visit	$50 Emergency Room Copayment per visit, waived if admitted to a Hospital	II.B.2.a
Urgent Care Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.2.b
Physicians and other covered Professionals (including mental health and substance use disorder treatment)	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided.)	III.B.2.c
House Calls by a physician	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	$15 Copayment per visit	III
Administration of Allergy Injections	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$5 Copayment per visit	III
Medical Therapies including Outpatient Surgery	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.2.f
Chiropractic Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided).	$15 Copayment per visit	III.B.2.c
Podiatric Services Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.2.c
Physical and Occupational Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.2.l

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 5: OUTPATIENT SERVICES

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Dental Care and Oral Surgery Services **Note:** Limited coverage provided. See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	III.B.2.n
Hospice Care (including inpatient Respite Care)	100% of Medicare allowable amount and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance). Benefits are covered less the Medicare Deductible	Medicare Deductible and the Hospice Coinsurance amount	Nothing	III.B.2.j
Diagnostic Tests and Procedures	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided).	III.B.2.e III.D.2.b
Ambulance	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.2.i
Durable Medical Equipment and Prosthetic Devices	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.2.g
Home Health Care Services	Medicare allowable amount	Nothing	Nothing	III.B.2.h
Home Infusion Therapy **Note:** Very limited coverage provided. See your *Benefit Handbook*	Generally None	All charges minus any coverage by Medicare	Nothing	III.D.5
Consultations Concerning Contraception and Hormone Replacement Therapy	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing	III.C.8
Kidney Dialysis	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.2.k

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** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 5: OUTPATIENT SERVICES

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Cardiac Rehabilitation Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.D.8

SECTION 6: MEDICARE ENHANCE PLAN BENEFITS

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

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Inpatient Mental Health Care				
For all Mental and Emotional disorders.	Nothing	Full benefits, to the extent medically necessary	Nothing	III.C.1
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Use Disorders).** **Note:** Benefits are provided for the same number of days as the coverage provided for a physical illness.				
Outpatient Mental Health Care				
For all Mental and Emotional disorders.	Nothing	Full benefits, less applicable Copayment per visit	$15 Copayment per visit	III.C.1
For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Use Disorders).** Benefits are provided for unlimited visits				

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 6: MEDICARE ENHANCE PLAN BENEFITS (Continued)

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Partial Hospitalization for Mental Health and Substance Use Disorder Treatment	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.l
Detoxification, Psychopharmacological, Psychological Testing, and Neuropsychological Assessment Services	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.C.1.d
Scalp Hair Prosthesis (Wigs)	Nothing	Up to $350 per calendar year	All charges in excess of $350	III.C.3
Low Protein Foods	Nothing	Up to $5,000 per calendar year	All charges in excess of $5,000	III.C.5
Special Formulas for Malabsorption	Nothing	Full benefits	Nothing	III.C.2
Hearing Aids (for Subscribers up to the age of 22) – $2,000 per hearing aid every 36 months, for each hearing impaired ear	Nothing	Up to $2,000 per hearing aid every 36 months, for each hearing impaired ear	All charges in excess of $2,000	III.C.11
Lipodystrophy Syndrome	Nothing	Full benefits	Nothing	III. C.12

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 7: ADDITIONAL COVERED SERVICES

Service	Medicare Parts A and B Pays: (if a Medicare covered service)	Medicare Enhance Pays: *	You Pay: *	Section:**
Diabetes Treatment	Covered less Medicare Deductible and Coinsurance amounts for Medicare covered items	Medicare Deductible and Coinsurance amounts for Medicare covered items. Full benefits for non-Medicare covered items. Less applicable Copayment per visit	$15 Copayment per visit	III.D.4
Medicare Covered Clinical Trials	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.2.p
Human Leukocyte Antigen Testing	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing	III.D.9
Hearing Aids Limited to $2,000 every 2 years	Nothing	First $500 covered in full, then remaining $1,500 covered at 80%	20% Coinsurance after the first $500 and all charges in excess of the benefit limit	III.D.7
Eye Exams Limited to one routine eye examination in each 24-month period	Nothing	Full benefits, less applicable Copayment per visit	$15 Copayment per visit	III.D.2.b
Smoking Cessation See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.D.11

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** Section numbers refer to your Medicare Enhance Benefit Handbook.

SECTION 8: WHAT THE PLAN DOES NOT COVER

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

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook* or the *Schedule of Benefits*.
2. Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.
4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.
5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")
6. Any products or services received in a hospital not certified to provide services to Medicare beneficiaries, unless the hospital is outside the United States.
7. Any product or service for which no charge would be made in the absence of insurance.

B. No Benefits will be provided by the Plan for any of the following unless they are covered by Medicare Parts A or B:

1. Any product or service that is not Medically Necessary.
2. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.
3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
4. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")
6. Private duty nursing.
7. Chiropractic care. (Note that Medicare provides limited benefits for chiropractic services to correct a subluxation of the spine.)
8. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
9. Rest or Custodial Care.
10. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses unless specifically listed as a Covered Service in your *Schedule of Benefits*. (Note that Medicare provides limited benefits for eye glasses or contact lenses after cataract surgery.).
11. Biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals or routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.

12. Foot orthotics, except as required for the treatment of severe diabetic foot disease.

13. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs)

14. Dental Services, except the specific dental services listed in your *Benefit Handbook* and this *Schedule of Benefits*. This exclusion includes, but is not limited to: (a) dental services for temporomandibular joint dysfunction (TMD); (b) extraction of teeth, except when specifically listed as a Covered Service; and (c) dentures, except that (1) the Plan will cover the Medicare coinsurance and deductible amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.")

15. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.

16. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.

17. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

18. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.

19. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)

20. Drugs or medications that can be self-administered.

21. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.

22. Planned home births.

23. Devices or special equipment needed for sports or occupational purposes.

24. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this *Benefit Handbook*.

25. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.

26. Acupuncture, aromatherapy, or alternative medicine

27. Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

SECTION 9: IMPORTANT NOTICES

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

Coverage will be subject to the terms, conditions, exclusions and limitation of Medicare-eligible services and supplies, and is subject to change pursuant to Medicare guidelines. This brochure is not intended as an explanation of Medicare benefits. Information and guidelines as established by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare, may be obtained by contacting your local Social Security office.

This Plan is only available to Subscribers enrolled through the Group Insurance Commission (GIC). Coverage under the Plan is effective on the first day of the month chosen by the GIC and renews year to year on the GIC's anniversary date unless terminated in accordance with the terms of the contract between the GIC and HPHC. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan.

*The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Copayment that applies.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

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) ប្រសូមជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ 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 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.

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