Schedule of Benefits

Medicare Enhance Plan for
Group Insurance Commission Members

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

This *Schedule of Benefits* summarizes your coverage under the Medicare Enhance Plan for Group Insurance Commission Members (the Plan) and states the Subscriber cost-sharing amounts that you must pay for Covered Services. However, it is only a summary of your benefits. Please see 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. You may contact an HPHC Member Services representative by calling **1-888-333-4742**. Deaf and hard-of-hearing Subscribers call 711.

Please refer to the Medicare handbook *Medicare & You* or contact the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE (1-800-633-4227)** or **www.medicare.gov** for information on your Medicare benefits.

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.

Section 2: Preventive Care Services

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

Medicare coverage includes a one-time "Welcome to Medicare" preventive visit 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 "Wellness" visit. Your first yearly "Wellness" visit must take place at least 12 months after your Part B enrollment or your "Welcome to Medicare" preventive visit, if you have 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; (5) Bone mass measurements; (6)

Glaucoma tests; (7) Medical nutrition therapy services; (8) Counseling to prevent tobacco use & tobacco-caused disease; (9) Colorectal cancer screenings, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema; and (10) Immunizations for flu, pneumococcal shots and hepatitis B shots.

Please refer to section *III.D. Additional Covered Services, Preventive Care Services* 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 handbook *Medicare & You*, for additional information on preventive care services that may benefit you.

Section 3: Emergency 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. Additional Covered Services, Services Received Outside the United States* of your *Benefit Handbook* for details of your coverage.

The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance *Benefit Handbook* for more information.

Section 4: Inpatient Services Covered by Medicare

Benefit Period: A Benefit Period is a way of measuring your use of services under Medicare Part A to determine Medicare coverage and your benefits under this Plan. A Benefit Period begins the first day of a Medicare-covered inpatient Hospital stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF). Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, for purposes of determining when a Benefit Period starts and ends, you are an inpatient of a Skilled Nursing Facility only when your care in the Skilled Nursing Facility meets certain skilled level of care standards established by the Medicare program. Please refer to the definition of "Skilled Nursing Care."

If you go into a Hospital or a Skilled Nursing Facility after one Benefit Period has ended, a new Benefit Period begins. Medicare puts no limit on the number of Benefit Periods covered by Medicare during your lifetime.

MEDICARE ENHANCE PLAN FOR
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Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Hospital Care (including acute, nonmedical health care institutions, psychiatric and rehabilitation hospitalization)				
First 60 days of a Benefit Period	All but Medicare Deductible amount	Medicare Deductible amount	Nothing	III.B.1
61st through 90th day of a Benefit Period	All but Medicare Coinsurance amount	Medicare Coinsurance amount	Nothing	
91st day and after of a Benefit Period – up to 60 Lifetime Reserve Days (if any)	All but Reserve Days Daily Coinsurance amounts	Medicare Lifetime Reserve Days Daily Coinsurance amounts	Nothing	
Non-Medicare Covered Services				
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* for details.	Nothing	All charges to the extent Medically Necessary	Nothing	III.B.1
Skilled Nursing Facility Care (SNF)				
First 20 days of a Benefit Period	Medicare allowable amount	Nothing	No charge	III.B.2
21st through 100th day of a Benefit Period	Medicare allowable amount minus SNF Daily Coinsurance	The SNF Daily Coinsurance amount	Nothing	
101st day and after of a Benefit Period	Nothing	Nothing	All charges	
Religious Non-medical Health Care Institutions				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.3

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Physicians and Other Health Professionals (inpatient services only)				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.1–3
Blood Transfusions				
First three pints per calendar year	Nothing	Medicare Blood Deductible	Nothing	XI. Special Services
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 and III.C.23

Section 5: Outpatient Services Covered by Medicare

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	
Acupuncture Treatment				
Note: Limited coverage provided by Medicare. See your *Benefit Handbook* for details.	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance less applicable Copayment per visit	$15 Copayment per visit	III.B.21
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.B.21
Ambulance Services				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.4

MEDICARE ENHANCE PLAN FOR
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Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	
Chiropractic Services				
Note: Limited coverage provided by Medicare. See your *Benefit Handbook* for details.	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.21
Clinical Trials				
Medicare-covered clinical trials	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.5
Dental Care and Oral Surgery Services				
Note: Limited coverage provided by Medicare. See your *Benefit Handbook* for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided)	$15 Copayment per visit	III.B.6
Diagnostic Tests and Procedures				
Diagnostic tests and procedures	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	Nothing (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.8
Durable Medical Equipment (DME) and Prosthetic Devices				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.9

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	
Emergency Room Care				
	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	III.B.10
Home Health Care				
	Medicare allowable amount	Nothing	Nothing	III.B.11
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 Medicare Deductible	Medicare Deductible and Hospice Coinsurance	Nothing	III.B.12 and III.C.27
House Calls (by a physician)				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.21
Kidney Dialysis				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.13
Medical Therapies				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.B.14

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	
Outpatient Prescription Drug Coverage				
	Your outpatient prescription drug coverage is not administered by HPHC. Please see your *SilverScript Prescription Drug Plan brochure* or call **SilverScript at 1-877-876-7214** for information on coverage of outpatient prescription drugs. Regardless of whether the SilverScript brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the *SilverScript Prescription Drug Plan brochure*.			
Outpatient Methadone Maintenance				
	Nothing	All charges	Nothing	III.B.16
Outpatient Surgery				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance	Nothing	III.B.17
Physical, Occupational and Speech Therapy				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.19
Podiatrist Services				
Note: Limited coverage provided by Medicare. See your *Benefit Handbook* for details.	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.B.21
Services of Physicians and Other Health 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	III.B.21

(Continued on next page)

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	You Pay:	
Services of Physicians and Other Health Professionals (including mental health and substance use disorder treatment) (Continued)				
			additional services are provided.)	
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.22

Section 6: Medicare Enhance Plan Benefits (Services May Not Be Covered by Medicare)

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

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Consultations Concerning Contraception and Hormone Replacement Therapy				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.C.24
Hearing Aids (for Subscribers up to the age of 22)				
– Limited to $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.25
Hearing Aids (for Subscribers age 22 and older)				
– Limited to $2,000 every two years for both ears combined	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 $2,000 benefit limit	III.C.25
Home Infusion Therapy				
Note: Very limited coverage provided by Medicare. See your *Benefit Handbook* for details.	Generally nothing	All charges minus any coverage by Medicare	Nothing	III.C.26

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Lipodystrophy Syndrome				
	Nothing	All charges	Nothing	III.C.28
Low Protein Foods				
– Up to $5,000 per calendar year	Nothing	All charges up to $5,000 per calendar year	All charges in excess of $5,000	III.C.29
Mental Health Care and Substance Use Disorder Treatment Services				
– **Inpatient Care** For all Mental and Emotional disorders. Biologically-Based and Rape Related Mental and Emotional Disorders (including Substance Use Disorder Treatment) **Note:** Benefits are provided for the same number of days as the coverage provided for a physical illness.	Nothing	All charges to the extent Medically Necessary	Nothing	III.C.30
– **Outpatient Care** For all Mental and Emotional disorders. For Biologically-Based and Rape Related Mental and Emotional Disorders (including Substance Use Disorder Treatment). Benefits are provided for unlimited visits.	Nothing	All charges, less applicable Copayment per visit	$15 Copayment per visit	
– **Partial Hospitalization**	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	
– **Detoxification and Psychopharmacological Services, 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	
Scalp Hair Prosthetics (Wigs)				
– Up to $350 per calendar year	Nothing	Up to $350 per calendar year	All charges in excess of $350	III.C.31
Special Formulas for Malabsorption				
	Nothing	All charges	No charge	III.C.32

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Telemedicine Virtual Visits				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit	$15 Copayment per visit	III.C.34

Section 7: Additional Covered Services

This section lists additional benefits that are covered by the Plan, which may not be covered by Medicare. If Medicare coverage is available for any service listed below, the coverage provided by the Plan is reduced by the Subscriber's Medicare benefits.

Medicare EnhancePlan Benefits	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook 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.35
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.B.7 and III.D.36
Human Leukocyte Antigen Testing				
	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts for Medicare covered items.	Nothing	III.D.38

Medicare EnhancePlan Benefits	Medicare Pays:	Medicare Enhance Pays:	You Pay:	Handbook Section:
Routine Eye Exam				
– Limited to 1 routine examination in each 24 month period	Nothing	All charges, less applicable Copayment per visit	$15 Copayment per visit	III.D.41
Smoking Cessation				
See your *Benefit Handbook*	Covered less Medicare Deductible and Coinsurance amounts	Medicare Deductible and Coinsurance amounts	Nothing	III.D.43

Section 8: What The Plan Does Not Cover

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

- Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in the *Benefit Handbook*, *Schedule of Benefits* or (if applicable) the Prescription Drug Brochure.
- 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.
- Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that the product or service be provided at a Medicare-approved 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 Medicare.
- Any product or service provided after the date on which your enrollment in the Plan has ended.
- Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")
- Any product or services received in a hospital not certified to provide services to Medicare beneficiaries, unless the hospital is outside the United States.
- Any product or service for which no charge would be made in the absence of insurance.

B. Unless covered by Medicare Parts A and B, no Benefits will be provided by the Plan for any of the following:

- Any product or service that is not Medically Necessary.
- 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.
- Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
- 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.

- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven or Investigational. (Please see the Glossary for the definition of "Experimental, Unproven or Investigational.")
- Any service or supply purchased from the internet.
- Private duty nursing.
- Chiropractic care. (Note that Medicare provides limited benefits for chiropractic services to correct a subluxation of the spine.)
- 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.
- Rest or custodial care.
- Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery.).
- 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.
- Foot orthotics, except as required for the treatment of severe diabetic foot disease.
- Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see section III.C.31. for the coverage provided for wigs.)
- 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 Deductible and Coinsurance amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.").
- Ambulance services except as specified in the *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.
- Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
- Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
- Refractive eye surgery, including but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Any product or service related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Deductible and Coinsurance amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
- Drugs or medications that can be self-administered.
- 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.

- Planned home births.
- Devices or special equipment needed for sports or occupational purposes.
- Charges for any product or service, 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*.
- Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
- Aromatherapy, or alternative medicine.
- 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.
- Telemedicine services involving e-mail, fax or non-secure texting.

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 limitations 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 each year on your 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.

MEDICARE ENHANCE PLAN FOR
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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) ប្រសិនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, បើងមានសេវាកម្មបកប្រែ 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, ໂດຍບໍ່ສັ້ງຄ່າ, 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.

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MEDICARE ENHANCE PLAN FOR
GROUP INSURANCE COMMISSION MEMBERS

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.