Schedule of Benefits

The Harvard Pilgrim Quality HMO Plan
MASSACHUSETTS

Please Note: This Plan includes a tiered Provider network. In this plan, Members pay different levels of Member Cost Sharing depending on the tier of the Provider delivering a Covered Benefit. The Harvard Pilgrim Quality HMO Plan Provider Directory includes provider tiering information and is available online at **www.harvardpilgrim.org/GIC** or by calling Member Services at **1-844-442-7324**. For TTY service, please call **711**.

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 Covered Benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Different Copayments apply depending on the type of Provider or the type of service. Please see the tables below for details.

You will find words in this Schedule of Benefits that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this Schedule of Benefits are defined in the Glossary in your Benefit Handbook.

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-844-442-7324**.

Tiered Providers

Most hospitals and physicians covered by the Plan are placed into one of two benefit levels or "tiers." Member Cost Sharing for these Providers depends upon the tier in which a Provider is placed. Tier 1 is the lower-cost tier and Tier 2 is the higher-cost tier. Only acute care hospitals, Primary Care Providers (PCPs) and medical specialists are assigned to one of two tiers. In some cases, a Provider may practice at multiple locations and have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.

Certain Quality HMO Plan Providers in specialties such as cardiology, gastroenterology and obstetrics/gynecology may also be Providers in internal medicine, pediatrics or other primary care specialties. When these Providers bill us for their services as PCPs, the applicable tiered PCP Copayment will apply. When these Providers bill us for their services as specialists, the applicable tiered specialty Copayment will apply.

Some Providers work from offices that are operated by a hospital. When services are rendered and billed from such an office or hospital outpatient department, a Tier 2 Specialist Copayment will be applied. However, please contact Member Services if you received care from a physician who specializes in internal, adolescent or geriatric medicine; family and general practice; pediatrics; or a midwife, nurse practitioner or a physician assistant in such an office to determine if you are subject to the PCP Copayment and which Tiered PCP Copayment will apply.

You can lower your out-of-pocket cost by selecting the physicians and hospitals in the lower-cost tier. The tables below list the Member Cost Sharing for each type of tiered service. The Harvard Pilgrim Quality HMO Plan Provider Directory lists all Plan Providers and their tier. You can access the Quality HMO Plan Provider Directory at **www.harvardpilgrim.org/GIC**. You may also obtain a paper copy of the directory, free of charge, by calling HPHC's Member Services Department at **1-844-442-7324**.

Please Note: When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 Hospital. If your Tier 1 PCP were to refer you to a Tier 2 hospital, you would pay the lower out-of-pocket costs for physician services but the higher out-of-pocket costs for hospital care.

Non-Tiered Benefits

For certain Covered Benefits Member Cost Sharing is not tiered. Your Member Cost Sharing for these Covered Benefits is listed in the tables below.

IMPORTANT POINTS TO REMEMBER

Under a Tiered Network Plan, your out-of-pocket costs will vary depending on whom you see and where you go for care. Please review and consider the following when seeking care under your Harvard Pilgrim Quality HMO Plan:

- You can lower your out-of-pocket cost by selecting the Providers and hospitals in the lower-cost tier.
- When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 Hospital.
- A Provider may practice at multiple locations and have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.
- Some Quality HMO Plan Providers have multiple offices and may be a Quality HMO Plan Provider at one location, and not at another. You must check with HPHC to make sure the services you seek are covered under your Plan for that specific Provider at that specific location.
- Some Quality HMO Plan Providers may be affiliated with hospitals that do not participate in the Quality HMO Plan. If a Quality HMO Plan Provider refers you to a hospital that is not in the Harvard Pilgrim Quality HMO Plan network, coverage will not be provided under your Plan.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Inpatient Hospital Copayments	
Medical care	Hospital Tier 1 Inpatient Copayment: $275 per admission Hospital Tier 2 Inpatient Copayment: $500 per admission
Mental health care (including the treatment of substance use disorders)	$275 Copayment per admission

General Cost Sharing Features:	Member Cost Sharing:
Inpatient Hospital Copayments (Continued)	
Please Note: There is an Inpatient Copayment maximum of one Medical or Mental Health Care inpatient Copayment per Member during each Quarter in a Plan Year.	
If you are readmitted to a medical hospital or mental health care hospital in a new Quarter, but within 30 calendar days of a discharge, your second Inpatient Hospital Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. This waiver is limited to a Plan Year basis. The bullets below list examples of when you can expect to pay a Inpatient Hospital Copayment and when you can expect that Copayment to be waived: • If you are admitted from March 2 until March 7, you are responsible for an Inpatient Hospital Copayment. If you are then readmitted from March 12 until March 15, the second Inpatient Hospital Copayment is waived because it is within the same Quarter as the first admission. • If you are admitted March 2 until March 7, and then readmitted April 3 until April 8, the second Inpatient Hospital Copayment is waived even though it is a new Quarter because it is within 30 calendar days of the original discharge. • If you are admitted March 2 until March 7, and then readmitted April 30 until May 2, you are responsible for the second Inpatient Hospital Copayment. The second admission occurred more than 30 days from the original discharge and it is a new Quarter. • If you are admitted June 2 until June 7, and then readmitted July 1 until July 4, you are responsible for the second Inpatient Hospital Copayment. Although the second admission occurred less than 30 days from the original discharge, it happened during a new Plan Year.	
Surgical Day Care Copayment	
	$250 Copayment per visit, or $150 Copayment per visit for outpatient eye and gastrointestinal surgical procedures received in an ambulatory surgical center (ASC), up to a maximum of 4 Surgical Day Care Copayments per Member per Plan Year. See the benefit for Surgical Day Care below for details.
Deductible – Medical	
	$400 per Member per Plan Year $800 per family per Plan Year
Coinsurance	
	20% Coinsurance for durable medical equipment and Skilled Nursing Facility care
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. The benefit table below is a summary of the services covered by your Plan. It also indicates your Member Cost Sharing, such as Copayment, Deductible or Coinsurance amounts. More detailed information about Covered Benefits can be found in your Benefit Handbook. 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 "Surgical Day Care."

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

Benefit	Member Cost Sharing
Ambulance and Medical Transport	
Emergency ambulance transport, including ground and/or air transportation	Deductible, then no charge
Non-emergency medical transport (ground only), including ambulance and wheelchair vans	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	$20 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Chiropractic Care	
– Limited to 20 visits per Plan Year	$20 Copayment per visit
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Emergency dental care (received within 3 days of injury) Reduction of fractures and removal of cysts or tumors	Office visits: Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible

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Benefit	Member Cost Sharing
Dental Services (Continued)	
	Surgical Day Care: $250 Copayment per visit, then Deductible
Please Note: The Covered Benefits below are **only** provided when the Member has a serious medical condition that makes it essential that he or she be admitted to a hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.	
– Removal of seven or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible
Diabetes Equipment and Supplies	
Diabetes equipment	Deductible, then no charge
Blood glucose monitors, insulin pumps and supplies and infusion devices	Deductible, then no charge
Diabetes equipment including needles and syringes for the administration of insulin are covered by this Plan. Insulin (other than insulin administered with an insulin pump) and other pharmacy supplies are covered under your outpatient prescription drug coverage, which is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs.	
Pharmacy supplies	See your **CVS Caremark Prescription Drug Plan brochure** for cost sharing amounts.
Dialysis	
Dialysis services	Deductible, then no charge
Installation of home equipment	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then no charge
Early Intervention Services	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Admission	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible **Please Note:** Emergency admission to a mental health facility is subject to a $275 Copayment per admission
If emergency admission is to a Non-Plan Provider, the Hospital Tier 2 $500 per-admission copayment and the deductible will apply.	

Benefit	Member Cost Sharing
Emergency Room Care	
	$100 Copayment per visit, then the Deductible
This $100 Copayment is waived if the patient is (1) transferred to either Observation Services or Surgical Day Care or (2) admitted directly to the hospital from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgical Day Care including Scopic Procedures" for the Member Cost Sharing that applies to these benefits.	
Gender Affirming Services	
	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible
Hearing Aids	
Hearing Aids (for Members up to the age of 22) – $2,000 per hearing aid every 24 months, for each hearing impaired ear	No charge
Hearing aids – (for Members ages 22 and older) – $1,700 per hearing aid every 24 months for each hearing impaired ear	No charge
Home Health Care Services	
	Deductible, then no charge No cost sharing or benefit limit applies to durable medical equipment, physical therapy, occupational therapy or speech therapy received as part of authorized home health care.
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Inpatient maternity care	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Inpatient routine nursery care	No charge
Non-routine inpatient services for the newborn	Deductible, then no charge
Inpatient rehabilitation	Deductible, then no charge
Skilled Nursing Facility limited to 100 days per Plan Year	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)	
– Advanced reproductive technologies are limited to 5 cycles per lifetime	Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit

Benefit	Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	Deductible, then no charge
Genetic testing	Deductible, then no charge
Radiology	Deductible, then no charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$100 Copayment per scan , then Deductible There is a maximum of one Copayment per Member per day.
Other diagnostic services	Deductible, then no charge
Low Protein Foods	
	Deductible, then no charge
Maternity Care - Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Non-routine outpatient prenatal and postpartum care	Deductible, then no charge
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 may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. Your outpatient prescription drug coverage is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs.	
Medical Formulas	
	Deductible, then no charge
Mental Health and Substance Use Disorder Treatment	
Inpatient services	$275 Copayment per admission
Intermediate care services	No charge
Annual mental health wellness examination performed by a licensed mental health professional **Please Note:** Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care	No charge
Outpatient services	Group therapy – $15 Copayment per visit Individual therapy – $20 Copayment per visit
Outpatient detoxification	No charge

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Benefit	Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
Acupuncture treatment for detoxification	$20 Copayment per visit
Outpatient medication management	$15 Copayment per visit
Outpatient methadone maintenance	No charge
Outpatient psychological testing and neuropsychological assessment	No charge
Prior Approval is not required to obtain substance use disorders treatment from a Quality HMO Plan Provider. In addition, when services are obtained from a Quality HMO Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Quality HMO Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary of your Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section J. Utilization Review Procedures of your Handbook.	
Observation Services	
	$100 Copayment per visit, then the Deductible
Ostomy Supplies	
	Deductible, then no charge
Outpatient Prescription Drug Coverage	
Your outpatient prescription drug coverage is administered by CVS Caremark. Please see your **CVS Caremark Prescription Drug Plan brochure** or call **CVS Caremark** at **1-877-876-7214** for information on coverage of outpatient prescription drugs. Regardless of whether the CVS Caremark brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the CVS Caremark Prescription Drug Plan brochure.	
Physician and Other Professional Office Visits (This includes all covered Quality HMO 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 our website at **www.harvardpilgrim.org/GIC**. 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, sickness and injury care Allergy tests and treatments Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per Plan Year)	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Administration of allergy injections Diagnostic screening and tests (including EKGs)	Deductible, then no charge

Benefit	Member Cost Sharing
Preventive Services and Tests	
Preventive care services, including all FDA approved generic contraceptive devices Under the federal health care reform law, many preventive services and tests are covered with no member cost sharing. For a complete list of covered preventive services, please see the Preventive Services notice on our website at **www.harvardpilgrim.org/GIC**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1-844-442-7324**	No charge
Under applicable 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 and tests go to HPHC's website at **www.harvardpilgrim.org/GIC**. You may also get a copy by calling the Member Services department at **1-844-442-7324**. HPHC will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.	
Prosthetics and Orthotics	
	Deductible, then no charge
Reconstructive Surgery	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	$20 Copayment per visit
Pulmonary rehabilitation therapy	$20 Copayment per visit
Speech-language and hearing services	$20 Copayment per visit
Occupational therapy limited to 30 visits per Plan Year Physical therapy limited to 30 visits per Plan Year	$20 Copayment per visit
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.	
Smoking Cessation	
Smoking Cessation (please see your Benefit Handbook for details on your coverage)	No charge

Benefit	Member Cost Sharing
Surgical Day Care including Scopic Procedures	
Outpatient surgery, including outpatient scopic procedures (except for eye and gastrointestinal procedures)	$250 Copayment per visit, then Deductible
Outpatient eye and gastrointestinal surgical procedures, including but not limited to colonoscopy, endoscopy and sigmoidoscopy – In an ambulatory surgical center (ASC) – In a hospital	 $150 Copayment per visit, then Deductible $250 Copayment per visit, then Deductible
	There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.
For a list of covered ambulatory surgical centers (ASC) go to our website at **www.harvardpilgrim.org/GIC**, go to your Quality HMO Plan "Provider Directory", click "Hospitals, Urgent Care, Labs and more"under Quicklinks on the right side of the page, then select "Ambulatory Surgical Center".	
Telemedicine Virtual Visit Services	
Outpatient telemedicine virtual visit services: - Medical services	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
- Mental health and substance use disorder services	No charge for the first 3 visits per Member per Plan Year, then $15 Copayment per visit for all visits after the first 3
For inpatient hospital care, see "Hospital - Inpatient Services."	
Temporomandibular Joint Dysfunction Services	
	Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).	
Urgent Care Services	
Doctor On Demand	$20 Copayment per visit
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For Doctor On Demand go to our website at **www.harvardpilgrim.org/GIC** , go to your Quality HMO Plan "Provider Directory", click "Hospitals, Urgent Care, Labs and more" under Quicklinks on the right side of the page, then select "Doctor On Demand Urgent Care".	
Convenience care clinic	$20 Copayment per visit
Urgent care center (including hospital urgent care center)	$20 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."	

Benefit	Member Cost Sharing
Vision Services	
Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: $20 per visit Ophthalmologist Copayment: – Tier 1 Specialist Copayment: $30 per visit – Tier 2 Specialist Copayment: $60 per visit
Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details and limits on your coverage)	Deductible, then no charge
Voluntary Sterilization	
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Surgical Day Care: $250 Copayment per visit, then Deductible
Voluntary Termination of Pregnancy (abortion)	
	No charge
Wigs and Scalp Hair Prostheses	
When needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia, or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury	No charge

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-844-442-7324 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-844-442-7324 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-844-442-7324 (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 1-844-442-7324（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 1-844-442-7324 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-442-7324 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم ألُلْغةِ **ألعربية** ، خَدَمات ألمُساعَدة ألُلْغَوية مُتَوفرة لك مَجانا.ً **إتصل على1-844-442-7324**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ តតកិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-844-442-7324 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-442-7324 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-442-7324 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-442-7324 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-844-442-7324 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-442-7324 (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. 1-844-442-7324 (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. 1-844-442-7324 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-442-7324 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-442-7324 (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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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.