Schedule of Benefits

HPHC Insurance Company, Inc.

PPO Access HSA 1650
RHODE ISLAND

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

There are two levels of coverage - In-Network and Out-of-Network.

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Please Note: Benefit limits can be met by any combination of In-Network and Out-of-Network services.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1-800-708-4414** for medical services
- **1-888-333-4742** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

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 **1-888-333-4742**.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of In-Network office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received 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 covered outpatient professional services received from specialty care providers.

Your Plan may have other cost sharing amounts. Please see the benefit table below for specific cost sharing 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 **1-888-333-4742**.

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." For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, see "Surgery - Outpatient."

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."

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	$1,650 for Individual Coverage per Plan Year $3,300 for Family Coverage per Plan Year	$3,300 for Individual Coverage per Plan Year $6,600 for Family Coverage per Plan Year
Your In-Network and Out-of-Network Deductible amounts are separate and do not accumulate toward each other		
Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible may be met by any combination of Members in a covered family (the Individual Coverage Deductible will never 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 except: – Any charges above the Allowed Amount	$5,200 for Individual Coverage per Plan Year $10,400 for Family Coverage per Plan Year – with a $5,200 embedded individual Out-of-Pocket Maximum per Plan Year	$15,300 for Individual Coverage per Plan Year $30,600 for Family Coverage per Plan Year – with a $15,300 embedded individual Out-of-Pocket Maximum per Plan Year
Your In-Network and Out-of-Network Out-of-Pocket Maximum amounts are separate and do not accumulate toward each other.		
Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member in a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the rest of the Plan Year. b. If any number of Members in a covered family together meet the Family Coverage Out-of-Pocket Maximum, then all Members in the covered family have no additional Member Cost Sharing for the rest of the Plan Year. No one Member of a covered family can pay more than the embedded individual Out-of-Pocket Maximum amount toward the Family Coverage Out-of-Pocket Maximum.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment		
	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then $50 Copayment per transport	Same as In-Network
Non-emergency air ambulance	Deductible, then $50 Copayment per transport	Same as in-Network
Non-emergency medical transport	Deductible, then $50 Copayment per transport	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Chiropractic Care, including Spinal Manipulation Therapy		
	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance
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	Deductible, then 20% Coinsurance
If your Plan provides coverage for pediatric dental services, please see your pediatric dental Schedule of Benefits and Benefit Handbook for coverage information.		
Dialysis		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Emergency Admission		
	Deductible, then $250 Copayment per admission	Same as In-Network

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Provider Member Cost Sharing
Emergency Room Care		
	Deductible, then $95 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
Hearing Aids		
– Limited to 1 hearing aid every 3 years, for each hearing impaired ear	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
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	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 100 days per Plan Year Inpatient rehabilitation and skilled nursing facility limits are combined	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Plan Year Inpatient rehabilitation and skilled nursing facility limits are combined	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Infertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then $25 Copayment per visit	Deductible, then 20% Coinsurance
Genetic testing and biomarker testing	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiology	Deductible, then $35 Copayment per visit	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Other diagnostic services, including allergy testing	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Provider Member Cost Sharing
Low Protein Foods		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care — Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
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 service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Maternity Care – Doula Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
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.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services, including Community Residence	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate care services	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient group therapy	Deductible, then $10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, detoxification and medication management	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance
Medication assisted treatment, including methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visits - group therapy	Deductible, then $10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visits - including individual therapy, detoxification and medication management	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Provider Member Cost Sharing
Observation Services		
	Deductible, then $250 Copayment per observation stay	Same as In-Network
Orthoses		
See Benefit Handbook for details on custom fabricated orthoses.	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all **In-Network** 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, sickness and injury care	**Level 1:** Deductible, then $15 Copayment per visit **Level 2:** Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Cost sharing level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which cost sharing 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, casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 20% Coinsurance
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 **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Provider Member Cost Sharing
Preventive Services and Tests (continued)		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), feta 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	Deductible, then 20% Coinsurance
Private Duty Nursing Services in the Home		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
Prosthetic Devices	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Breast prostheses	Deductible, then no charge	Deductible, then 20% Coinsurance
Reconstructive Surgery		
Reconstructive Surgery	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."	
Mastectomy Care	Deductible, then no charge	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Occupational therapy - Rehabilitation Services - limited to 30 visits per Plan Year - Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Physical therapy - Rehabilitation Services - limited to 30 visits per Plan Year - Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Speech therapy - Rehabilitation Services - limited to 30 visits per Plan Year - Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical, occupational and speech 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.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Provider Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy and sigmoidoscopy	Deductible, then $150 Copayment per visit	Deductible, then 20% Coinsurance
Endoscopy	Deductible, then $150 Copayment per visit	Deductible, then 20% Coinsurance
See Preventive Services and Tests above for coverage of preventive colonoscopies. In accordance with Rhode Island law, a follow up colonoscopy with an In-Network Plan Provider will be covered in full if the results of an initial screening colonoscopy (or other screening medical test or procedure) for colorectal cancer is abnormal.		
Surgery – Outpatient		
	Deductible, then $150 Copayment per visit	Deductible, then 20% Coinsurance
Telemedicine Virtual Visit Services - Outpatient		
	Level 1: Deductible, then $15 Copayment per visit **Level 2:** Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Urgent Care Services		
Doctor On Demand	Deductible, then no charge	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.		
Convenience care clinic	Deductible, then $15 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine adult eye examinations - limited to 1 exam per Plan Year	$15 Copayment per visit	Deductible, then 20% Coinsurance
Routine pediatric eye examinations (including contact lens fitting) - limited to 1 exam per Plan Year	No charge	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see your Pediatric Vision Care Schedule of Benefits and Benefit Handbook for more information.		
Voluntary Sterilization in a Physician's Office		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
– Limited to $350 per wig See the Benefit Handbook for details. The number of wigs provided in accordance with RI law per Plan Year is not limited.	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

ID:_RX0000201291

Prescription Drug Schedule of Benefits

HPHC Insurance Company, Inc.

CORE RI Five-Tier Prescription Drug Plan
RHODE ISLAND

Cost Sharing Features:	Member Cost Sharing:
Deductible	
	Please see your medical *Schedule of Benefits*
Please Note: Your Plan includes the Preventive Drug Benefit. Your Deductible will not apply to certain medications used for preventive care.	
Out-of-Pocket Maximum	
	Please see your medical *Schedule of Benefits*
Your Member Cost Sharing for up to a 30-day supply at a retail pharmacy is:	
Tier 1:	Deductible, then $5 Copayment per prescription or prescription refill.
Tier 2:	Deductible, then $45 Copayment per prescription or prescription refill.
Tier 3:	Deductible, then $70 Copayment per prescription or prescription refill.
Tier 4:	Deductible, then $90 Copayment per prescription or prescription refill.
Tier 5:	Deductible, then 25% Coinsurance subject to a maximum Coinsurance* amount of $150 per prescription or prescription refill.
Infertility Drugs	All infertility drugs will apply 20% Coinsurance. Copayments and/or Coinsurance maximums listed above (if any) will never apply. If a Deductible applies to a particular tier, you will be responsible for paying the Deductible, then 20% Coinsurance.
Your Member Cost Sharing for up to a 90-day supply of maintenance medications at a retail pharmacy is:	
Tier 1:	Deductible, then $15 Copayment per prescription or prescription refill.
Tier 2:	Deductible, then $135 Copayment per prescription or prescription refill.
Tier 3:	Deductible, then $210 Copayment per prescription or prescription refill.
Tier 4:	Deductible, then $270 Copayment per prescription or prescription refill.
Tier 5:	Deductible, then 25% Coinsurance subject to a maximum Coinsurance* amount of $450 per prescription or prescription refill.
Harvard Pilgrim's mail service prescription drug program.	
You may purchase up to a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program. Your mail service Member Cost Sharing for a up to a 90-day supply is:	
Tier 1:	Deductible, then $10 Copayment per prescription or prescription refill.
Tier 2:	Deductible, then $90 Copayment per prescription or prescription refill.
Tier 3:	Deductible, then $210 Copayment per prescription or prescription refill.
Tier 4:	Deductible, then $270 Copayment per prescription or prescription refill.
Tier 5:	Deductible, then 25% Coinsurance subject to a maximum Coinsurance* amount of $450 per prescription or prescription refill.

*Once the Deductible is met, Coinsurance is based on the full cost of the medication. The full cost will be the lower of the participating pharmacy's retail price or the price of the medication at Harvard Pilgrim's discount rate.

EFFECTIVE DATE: 01/01/2025

Important Notes:

A two (2) pack of epinephrine auto-injectors or cartridges is covered once every 12 months with no Member Cost Sharing. Additional epinephrine auto-injectors or cartridges will be subject to Member Cost Sharing.

Copayments and Coinsurance for certain high dollar specialty drugs, as defined under Rhode Island law, will not exceed $150 for up to a 30 day supply.

Please see Appendix A of your Benefit Handbook for more information on your outpatient Prescription Drug Benefit, including the tier definitions.

A summary of your cost sharing amounts for your prescription drug coverage is also shown on your Plan identification (ID) card. 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.

ID: VS0000201186
DATE: 01/01/2025

Pediatric Vision Care Schedule of Benefits

HPHC Insurance Company, Inc.
RHODE ISLAND

Dependents up to the age of 19 are eligible for coverage of vision hardware as described below. 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 and in your Benefit Handbook. In addition, coverage is also provided for **(C)** Medically Necessary contact lenses, and **(D)** Medically Necessary low vision services.

Please see *Appendix B: Pediatric Vision Care Benefits* in your Benefit Handbook for additional information.

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

Benefit	Member Cost Sharing
(A) Prescription eyeglass frames and lenses – Limited to 1 pair every 12 months	Covered in full for the first $50, then 50% Coinsurance.
(B) Prescription contact lenses – Limited to 1 purchase every 12 months **Please Note:** Daily wear disposable lenses are limited to one purchase of a 6 month supply every 12 months.	Covered in full for the first $50, then 50% Coinsurance.
(C) Medically Necessary contact lenses (see the Benefit Handbook for details)	Covered in full for the first $50, then 50% Coinsurance.
(D) Low vision services (see the Benefit Handbook for details)	Covered in full for the first $50, then 50% Coinsurance.

ID: DN0000201238
DATE: 01/01/2025

Pediatric Dental Schedule of Benefits

HPHC Insurance Company, Inc.
PPO Access HSA
RHODE ISLAND

Dependents up to the age of 19 are eligible for the Covered Dental Services listed below when such Dental Services are Necessary and are provided by or under the direction of a Dental Provider.

Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Please see *Appendix C* of your Benefit Handbook for additional details.

Certain capitalized words in this section have special meanings. We have defined these words in your Benefit Handbook. Please see *Section II: Glossary* and *Appendix C: Pediatric Dental Benefit (for children up to the age of 19)* for more details.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

Please Note: Benefit limits can be met by any combination of In-Network and Out-of-Network services.

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

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE I SERVICES: *PREVENTIVE & DIAGNOSTIC COVERED SERVICES*		
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) – Limited to 1 set every 6 months	No charge	20% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE I SERVICES: *PREVENTIVE & DIAGNOSTIC COVERED SERVICES* (Continued)		
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) – Limited to 1 film every 60 months	No charge	20%Coinsurance
Periodic Oral Evaluation (Checkup Exam) – Limited to 1 every 6 months	No charge	20%Coinsurance
Preventive Services		
Dental Prophylaxis (Cleanings) – Limited to 1 every 6 months	No charge	20% Coinsurance
Fluoride Treatments – Limited to 2 treatments per 12 months.	No charge No charge for children up to age 5.	20% Coinsurance
Sealants (Protective Coating) – Limited to one sealant per tooth every 36 months.	No charge	20% Coinsurance
Space Maintainers	No charge	20% Coinsurance
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES*		
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery		
Amalgam Restorations (Silver Fillings)	25% Coinsurance	25% Coinsurance
Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only.	25% Coinsurance	25% Coinsurance
Endodontics(Root Canal Therapy) performed on anterior or posterior primary teeth – Limited to once per tooth per lifetime.	25% Coinsurance	25% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	25% Coinsurance	25% Coinsurance
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	25% Coinsurance	25% Coinsurance

PEDIATRIC DENTAL SCHEDULE OF BENEFITS - *RHODE ISLAND*

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES* (Continued)		
Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 24 months.	25% Coinsurance	25% Coinsurance
Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following completion of active periodontal therapy	25% Coinsurance	25% Coinsurance
Simple Extractions (Simple tooth removal)	25% Coinsurance	25% Coinsurance
Oral Surgery, including Surgical Extraction	25% Coinsurance	25% Coinsurance
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) General anesthesia is covered when clinically necessary.	25% Coinsurance	25% Coinsurance
TYPE III SERVICES: *MAJOR RESTORATIVE COVERED SERVICES*		
Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50% Coinsurance	50% Coinsurance
Endodontics(root canal therapy) performed on anterior teeth, bicuspids, and molars – Limited to once per tooth per lifetime.	50% Coinsurance	50% Coinsurance
Endodontic Surgery	50% Coinsurance	50% Coinsurance
Fixed Prosthetics (Bridges) – Limited to once per tooth per 60 months.	50% Coinsurance	50% Coinsurance
Occlusal guards for Members age 13 and older – Limited to one guard every 12 months.	50% Coinsurance	50% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE III SERVICES: *MAJOR RESTORATIVE COVERED SERVICES* (Continued)		
Periodontal Surgery (Gum Surgery) – Limited to one quadrant or site per 36 months per surgical area.	50% Coinsurance	50% Coinsurance
Removable Prosthetics (Full or partial dentures) – Limited to one per 60 months.	50% Coinsurance	50% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50% Coinsurance	50% Coinsurance
Oral Surgery, including Surgical Extraction	50% Coinsurance	50% Coinsurance
Implants		
Implant Placement – Limited to once per 60months. Implant Supported Prosthetics – Limited to once per 60 months. Implant Maintenance Procedures – Limited to once per 60 months. Repair Implant Supported Prosthesis by Report – Limited to once per 60 months. Repair Implant Abutment by Support – Limited to once per 60 months. Radiographic/Surgical Implant Index by Report – Limited to once per 60 months.	50% Coinsurance	50% Coinsurance
TYPE IV SERVICES: *MEDICALLY NECESSARY ORTHODONTIA*		
Orthodontic Services Covered Benefits will be paid in equal installments over the course of the entire orthodontic treatment plan as agreed upon between you and your Dental Provider, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.		

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE IV SERVICES: *MEDICALLY NECESSARY ORTHODONTIA* (Continued)		
Coverage is provided for Medically Necessary comprehensive orthodontic treatment including, but not limited to cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. **Note:** Prior Authorization is required for all orthodontic treatment.	50% Coinsurance	50% Coinsurance

General List of Exclusions
RHODE ISLAND

The following list identifies services that are generally excluded from Harvard Pilgrim Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion
Alternative Treatments
• Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment, Orthoses and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven, or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Non-custom and prefabricated foot orthotics, fittings and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member diagnosed with severe diabetic foot disease or systemic circulatory illnesses that compromise the blood supply to the foot. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
Maternity Services
• Planned home births. • The following doula services or expenses: travel expenses and mileage; any childcare services or services for children other than the newborn; housekeeping assistance; doula services provided in connection with home births.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
Mental Health and Substance Use Disorder Treatment
• Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care. • Sensory integrative praxis tests. • Mental health and substance use disorder treatment that is (1) provided to Members 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. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued Medical Necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, transplantation or drug therapy. • Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. • Skin abrasion procedures performed as a treatment for acne. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Treatments and procedures related to appearance including but not limited to: abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g., cheek, calf, pectoral, gluteal); lip reduction/enhancement; pannicudectomy; removal of redundant skin; silicone injections (e.g., for breast enlargement), except for what is Medical Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

Exclusion
Providers
• Charges for services which were provided after the date on which your membership ends. • 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 Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction
• Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • Birth control drugs, implant and devices. This exclusion ver had this happen in Arbortext — may apply when coverage is provided by a church or church controlled organization, as allowed by law. Check this Schedule of Benefits to see if your Plan covers this benefit. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility treatment for Members who are not medically infertile. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail or fax or an automated computer program used to diagnose and/or treat ocular or refractive conditions. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Private duty nursing as follows: services when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as a companion or sitter; services provided by a member of your household or the cost of any care provided by a member's relatives (by blood, marriage, or adoption); services after the caregiver or patient has demonstrated the ability to carry out the plan of care; services that are provided outside the home (e.g., school, nursing facility or assisted living facility); services that duplicate or overlap services (e.g., when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit); services for observation only; services of a nurse's aide; services for a person without an available caregiver in the home (24 hour private duty nursing is not covered); maintenance care when the condition has stabilized, including routine ostomy care or tube feeding administration, or if the anticipated need is indefinite; respite care (e.g., care during a caregiver's vacation) or private duty nursing so that the caregiver may attend work or school. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Over the counter hearing aids. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
All Other Exclusions
• Any service or supply furnished in connection with a non-Covered Benefit. • Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as described in the Plan's *Benefit Handbook*. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Reimbursement for travel expenses. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's *Benefit Handbook* or this Schedule of Benefits. • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • Transportation by wheelchair van. • Voice modification surgery, except when Medical Necessary for gender affirming services. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

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 أللُغةِ **ألعربية** ، خَدَمات ألمُساعَدة أللُغَوية مُتَوفرة لك مَجانا.ً **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ 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 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 (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and 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, or sex (including pregnancy, sexual orientation, and 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.