



Medical Benefit Highlights

Keystone HMO Gold Proactive

| Covered Services | Your Costs (You pay) | | | |
|---|---------------------------|--------------------------|--------------------------|-----------------------|
| | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Benefits per Contract Year | | | | |
| Deductible Individual/Family | \$0/\$0 | | | Not covered |
| Out-of-Pocket Maximum ¹ (Embedded) ² Individual/Family | | \$8,150/\$16,300 | | Not covered |
| Coinsurance | 0% | 20% | 30% | Not covered |
| Preventive Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Preventive Care | No charge | No charge | No charge | Not covered |
| Preventive Colonoscopy | | | | |
| Preventive Plus Providers | No charge | No charge | No charge | Not covered |
| Hospital Based | \$750 | \$750 | \$750 | Not covered |
| Physician Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Primary Care Physician (PCP) Office Visit | \$15 | \$30 | \$45 | Not covered |
| Specialist Office Visit | \$40 | \$60 | \$80 | Not covered |
| Retail Health Clinic Visit | \$15 | \$30 | \$45 | Not covered |
| Telemedicine (through MDLive®) | \$20 Fee | \$20 Fee | \$20 Fee | Not covered |
| Urgent Care Visit | \$100 | \$100 | \$100 | Not covered |
| Therapy Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Physical Therapy (30 visits/year) ³ | | | | |
| Freestanding | \$60 | \$60 | \$60 | Not covered |
| Hospital Based | \$60 | \$60 | \$60 | Not covered |
| Occupational Therapy (30 visits/year) ³ | | | | |
| Freestanding | \$60 | \$60 | \$60 | Not covered |

| | | | | |
|--|--|--|--|-----------------------------|
| Hospital Based | \$60 | \$60 | \$60 | Not covered |
| Speech Therapy (30 visits/year) | \$60 | \$60 | \$60 | Not covered |
| Cognitive Therapy | Not covered | Not covered | Not covered | Not covered |
| Emergency Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Emergency Room (copay not waived if admitted) | \$400 | \$400 | \$400 | Covered at In-Network level |
| Emergency Ambulance | \$150 | \$150 | \$150 | Covered at In-Network level |
| Non-Emergency Ambulance | \$200 | \$200 | \$200 | Not covered |
| Hospital Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Inpatient Hospital Services | \$350/Day; max of 5 copays per admission | \$700/Day; max of 5 copays per admission | \$1,100/Day; max of 5 copays per admission | Not covered |
| Maternity Hospital Services | \$350/Day; max of 5 copays per admission | \$700/Day; max of 5 copays per admission | \$1,100/Day; max of 5 copays per admission | Not covered |
| Inpatient Professional Services (includes Maternity) | No charge | 20% | 30% | Not covered |
| Outpatient Surgery | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Freestanding | \$150 | \$550 | \$1,000 | Not covered |
| Hospital Based | \$150 | \$550 | \$1,000 | Not covered |
| Outpatient Professional Services | No charge | 20% | 30% | Not covered |
| Outpatient Diagnostics | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Diagnostic Medical (EKG) | \$60 | \$60 | \$60 | Not covered |
| Routine Radiology (X-Ray) | | | | |
| Freestanding | \$60 | \$60 | \$60 | Not covered |
| Hospital Based | \$60 | \$60 | \$60 | Not covered |
| Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan) | | | | |
| Freestanding | \$120 | \$120 | \$120 | Not covered |

| | | | | |
|--|--|--|--|-----------------------|
| Hospital Based | \$120 | \$120 | \$120 | Not covered |
| Outpatient Lab and Pathology | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Freestanding | No charge | No charge | No charge | Not covered |
| Hospital Based | No charge | No charge | No charge | Not covered |
| Other Medical Services | Tier 1 - Preferred | Tier 2 - Enhanced | Tier 3 - Standard | Out-of-Network |
| Spinal Manipulations (20 visits/year) | \$50 | \$50 | \$50 | Not covered |
| Standard Injectables | 20% | 20% | 20% | Not covered |
| Allergy Injections | 20% | 20% | 20% | Not covered |
| Biotech/Specialty Injectables | | | | |
| Home/Office | 50% | 50% | 50% | Not covered |
| Outpatient | 50% | 50% | 50% | Not covered |
| Chemotherapy | No charge | 20% | 30% | Not covered |
| Dialysis | \$25 | \$75 | \$125 | Not covered |
| Skilled Nursing Facility (120 days/year) | \$175/Day; max of 5 copays per admission | \$175/Day; max of 5 copays per admission | \$175/Day; max of 5 copays per admission | Not covered |
| Home Health (60 visits/year) | No charge | 20% | 30% | Not covered |
| Hospice | No charge | No charge | No charge | Not covered |
| Durable Medical Equipment (DME) | 50% | 50% | 50% | Not covered |
| Mental Health – Outpatient (includes serious mental illness and substance abuse) | \$40 | \$40 | \$40 | Not covered |
| Mental Health – Inpatient (includes serious mental illness and substance abuse) | \$350/Day; max of 5 copays per admission | \$350/Day; max of 5 copays per admission | \$350/Day; max of 5 copays per admission | Not covered |

¹ Out-of-pocket maximum is combined for all tiers.

² Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

³ Physical Therapy and Occupational Therapy combined visit limit.



Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/SGBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Drug Benefit Highlights

Keystone HMO Gold Proactive Rx

Covered Services

Benefits per Contract Year

| |
|--|
| Deductible Individual/Family |
| Out-of-Pocket Maximum Individual/Family |
| Formulary ¹ |
| Dispense as Written (DAW) Provision ² |

Retail Pharmacy

| |
|--|
| Tier 1 Low-Cost Generic Drugs |
| Tier 2 Generic Drugs |
| Tier 3 Preferred Brand Drugs |
| Tier 4 Non-Preferred Drugs |
| Tier 5 Self-Administered Specialty Drugs |
| Dispensing Limits ³ |

Mail Order Pharmacy Available for maintenance drugs

| |
|--|
| Tier 1 Low-Cost Generic Drugs |
| Tier 2 Generic Drugs |
| Tier 3 Preferred Brand Drugs |
| Tier 4 Non-Preferred Drugs |
| Tier 5 Self-Administered Specialty Drugs |
| Dispensing Limits ⁴ |

Drug Coverage

| |
|---|
| ACA Preventive Drugs |
| Compound Medications |
| Contraceptives |
| Diabetic Supplies (i.e., test strips) |
| Glucometers (no copayment/coinsurance required at participating pharmacies) |
| Insulin |
| Insulin Needles and Syringes |
| Lancets (no copayment/coinsurance required at participating pharmacies) |
| Prescribed Tobacco Cessation Drugs (RX and OTC) |
| Retin-A (up to Age 35) |
| Allergy Serum |

Your Costs (You pay)

In-Network

| |
|-----------------------|
| \$0/\$0 |
| Combined with Medical |
| Value |
| Mandatory Generic |

Out-of-Network

| |
|-----------------------|
| \$0/\$0 |
| Combined with Medical |
| |
| |

In-Network

| |
|-------------------|
| \$4 |
| \$15 |
| 50% up to \$200 |
| 50% up to \$300 |
| 50% up to \$1,000 |
| 30 day supply max |

Out-of-Network

| |
|-------------------|
| 30% Reimbursement |
| 30% Reimbursement |
| 30% Reimbursement |
| 30% Reimbursement |
| Not covered |
| 30 day supply max |

In-Network

| |
|-------------------|
| \$8 |
| \$30 |
| 50% up to \$400 |
| 50% up to \$600 |
| Not covered |
| 90 day supply max |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |

In-Network

| |
|-------------|
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Not covered |

Out-of-Network

| |
|-------------|
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Not covered |

| | | |
|---|-------------|-------------|
| Biologicals, Investigational/Experimental Drugs | Not covered | Not covered |
| Blood, Blood Plasma | Not covered | Not covered |
| Drugs used for Cosmetic Purposes | Not covered | Not covered |
| Immunization Agents | Not covered | Not covered |
| Injectable Fertility Drugs | Not covered | Not covered |
| Non-Federal Legend Drugs | Not covered | Not covered |
| Over-The-Counter Drugs (Non-Prescription) | Not covered | Not covered |
| Weight Control Drugs | Not covered | Not covered |

¹ Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto www.ibx.com.

² When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.

³ Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.

⁴ Mail order cost-sharing for 1-30 day supplies is equal to the in-network retail cost-sharing. Up to a 90-day supply of drugs to treat chronic conditions also available at Walgreens.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/SGBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered. Drugs used to treat hemophilia are not covered.

The network required for this plan is the FutureScripts® Preferred Pharmacy Network. The FutureScripts® Preferred Pharmacy Network is a subset of the national retail pharmacy network, including most major chains and local pharmacies except Rite Aid. Out-of-Network benefits apply to prescriptions filled at Non-Preferred pharmacies and you must pay the full retail price for your prescription then file a paper claim for reimbursement. FutureScripts® is an independent company providing pharmacy benefit management service.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Vision Benefit Highlights

Pediatric/Adult Vision SML HMO/POS Stnd w/o Med Ded

PEDIATRIC BENEFITS

| Covered Services | Your Costs (You pay) | |
|---|-------------------------|----------------|
| Benefits | In-Network ¹ | Out-of-Network |
| Annual Plan Maximum | Unlimited | Not covered |
| Deductible (Individual/Family) | \$0/\$0 | Not covered |
| Out-of-Pocket Maximum (Individual/Family) | \$0/\$0 | Not covered |
| Exam | In-Network ¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Routine Eye Exam at Davis Participating Providers | No charge | Not covered |
| Lenses | In-Network ¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Single Vision Lenses | No charge | Not covered |
| Bifocal Lenses | No charge | Not covered |
| Trifocal Lenses | No charge | Not covered |
| Lenticular Lenses | No charge | Not covered |
| Lens Options ² | | |
| Standard Progressive Lenses | \$50 | Not covered |
| Premium Progressive Lenses | \$90 | Not covered |
| Ultra Progressive Lenses | \$140 | Not covered |
| Polycarbonate Lenses ³ | No charge | Not covered |
| Photosensitive Lenses | \$65 | Not covered |
| High-Index Lenses | \$55 | Not covered |
| Polarized Lenses | \$75 | Not covered |
| Lens Coatings | | |
| Tinted Plastic Lenses | No charge | Not covered |
| UV-Coated Lenses | No charge | Not covered |
| Scratch-Resistant Lenses | No charge | Not covered |
| Scratch-Protection Plan Single Vision Lenses | \$20 | Not covered |
| Scratch-Protection Plan Multifocal Vision Lenses | \$20 | Not covered |
| Anti-Reflective Standard Lenses | \$35 | Not covered |
| Anti-Reflective Premium Lenses | \$48 | Not covered |
| Anti-Reflective Ultra Lenses | \$60 | Not covered |
| Frames | In-Network ¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Davis Collection Fashion Frames | No charge | Not covered |
| Davis Collection Designer Frames | No charge | Not covered |

| | | |
|---|-------------------------------|-----------------------|
| Davis Collection Premier Frames | No charge | Not covered |
| Non-Davis Collection Frames | Up to \$150 Allowance | Not covered |
| Contact Lenses (in lieu of glasses) | In-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Davis Collection Standard Daily Contact Lenses & Evaluation | No charge | Not covered |
| Davis Collection Specialty Contact Lenses & Evaluation | No charge | Not covered |
| Davis Collection Disposable Contact Lenses & Evaluation | No charge | Not covered |
| Medically-Necessary Contact Lenses ⁵ | No charge | Not covered |

ADULT BENEFITS

| Covered Services | Your Costs (You pay) | |
|---|-------------------------------|-----------------------|
| Benefits | In-Network¹ | Out-of-Network |
| Annual Plan Maximum | Unlimited | |
| Deductible (Individual/Family) | \$0/\$0 | Not covered |
| Out-of-Pocket Maximum (Individual/Family) | \$0/\$0 | Not covered |
| Exam | In-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Routine Eye Exam at Davis Participating Providers | No charge | Not covered |
| Lenses | In-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Calendar Year | Not covered |
| Single Vision Lenses | No charge | Not covered |
| Bifocal Lenses | No charge | Not covered |
| Trifocal Lenses | No charge | Not covered |
| Lenticular Lenses | No charge | Not covered |
| Lens Options ² | | |
| Standard Progressive Lenses | \$65 | Not covered |
| Premium Progressive Lenses | \$105 | Not covered |
| Ultra Progressive Lenses | \$140 | Not covered |
| Polycarbonate Lenses ³ | \$35 | Not covered |
| Photosensitive Lenses | \$70 | Not covered |
| High-Index Lenses | \$60 | Not covered |
| Polarized Lenses | \$75 | Not covered |
| Lens Coatings | | |
| Tinted Plastic Lenses | \$15 | Not covered |
| UV-Coated Lenses | No charge | Not covered |
| Scratch-Resistant Lenses | No charge | Not covered |

| | | |
|---|---|--------------------------------------|
| Scratch-Protection Plan Single Vision Lenses | \$20 | Not covered |
| Scratch-Protection Plan Multifocal Vision Lenses | \$40 | Not covered |
| Anti-Reflective Standard Lenses | \$40 | Not covered |
| Anti-Reflective Premium Lenses | \$55 | Not covered |
| Anti-Reflective Ultra Lenses | \$69 | Not covered |
| Frames | | |
| Benefit Frequency | In-Network¹ 1 / Calendar Year | Out-of-Network Not covered |
| Davis Collection Fashion Frames | No charge | Not covered |
| Davis Collection Designer Frames | \$15 | Not covered |
| Davis Collection Premier Frames | \$40 | Not covered |
| Non-Davis Collection Frames | Up to \$130 Allowance (plus a 20% discount on any overage) ⁴ | Not covered |
| Visionworks Frames Option | Up to \$180 Allowance (plus a 20% discount on any overage) at Visionworks locations nationwide ⁴ | Not covered |
| Contact Lenses (in lieu of glasses) | | |
| Benefit Frequency | In-Network¹ 1 / Calendar Year | Out-of-Network Not covered |
| Davis Collection Standard Daily Contact Lenses & Evaluation | No charge | Not covered |
| Davis Collection Specialty Contact Lenses & Evaluation | No charge | Not covered |
| Davis Collection Disposable Contact Lenses & Evaluation | No charge | Not covered |
| Non-Davis Collection Contact Lenses & Evaluation | Up to \$130 Allowance (plus a 15% discount on any overage) ⁴ | Not covered |
| Medically-Necessary Contact Lenses ⁵ | No charge | Not covered |

¹ Participating Davis provider benefit.

² Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

³ Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

⁴ Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

⁵ Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/SGBooklet or call 1-800-ASK-BLUE (TTY: 711).

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Administered by Davis Vision.



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Dental Benefit Highlights

Pediatric Dental SML DHMO

PEDIATRIC BENEFITS

| Covered Services | Your Costs (You pay) | |
|---|--|----------------|
| Benefits per Contract Year | In-Network | Out-of-Network |
| Annual Plan Maximum | Unlimited | Not covered |
| Deductible (per child) | \$0 | Not covered |
| Out-of-Pocket Maximum (per child) | Medical out-of-pocket maximum applies. | Not covered |
| Medically Necessary Orthodontic Maximum (per child) | Unlimited | Not covered |
| Coverage Type | In-Network | Out-of-Network |
| Diagnostic & Preventive Services | No charge | Not covered |
| Basic Services | \$0 - \$400 | Not covered |
| Major Services | \$0 - \$1,100 | Not covered |
| Medically Necessary Orthodontics | \$130 - \$3,500 | Not covered |
| Cosmetic Orthodontic Services | Not covered | Not covered |
| Key Covered Services | In-Network | Out-of-Network |
| Exams | No charge | Not covered |
| Cleanings | No charge | Not covered |
| Bitewing X-rays | No charge | Not covered |
| Fluoride Treatments | No charge | Not covered |
| Sealants | \$0 - \$8 | Not covered |
| Basic Restorative (Fillings) | \$0 - \$400 | Not covered |
| Oral Surgery | \$0 - \$1,100 | Not covered |
| Endodontics | \$0 - \$1,100 | Not covered |
| Periodontics | \$0 - \$1,100 | Not covered |
| Crowns | \$0 - \$1,100 | Not covered |
| Bridges | \$0 - \$1,100 | Not covered |
| Dentures | \$0 - \$1,100 | Not covered |

This summary represents only a partial listing of benefits of the Dental Plan described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by dental policy. As a result, this dental plan may not cover all of your dental or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/SGBooklet or call 1-800-ASK-BLUE (TTY: 711).

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Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan 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, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.