Independence

Medical Benefit Highlights

Keystone HMO Silver Proactive

Covered Services	Your Costs (You pay)			
Benefits per Contract Year	**Tier 1 - Preferred**	**Tier 2 - Enhanced**	**Tier 3 - Standard**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$0/$0	$6,000/$12,000		Not covered
Out-of-Pocket Maximum[2] (Embedded)[3] Individual/Family		$8,150/$16,300		Not covered
Coinsurance	0%	5%	10%	Not covered
Preventive Services	**Tier 1 - Preferred**	**Tier 2 - Enhanced**	**Tier 3 - Standard**	**Out-of-Network**
Preventive Care	No charge	No charge no deductible	No charge no deductible	Not covered
Preventive Colonoscopy				
Preventive Plus Providers	No charge	No charge no deductible	No charge no deductible	Not covered
Hospital Based	$750	$750 no deductible	$750 no deductible	Not covered
Physician Services	**Tier 1 - Preferred**	**Tier 2 - Enhanced**	**Tier 3 - Standard**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	$40	$60 no deductible	$70 no deductible	Not covered
Specialist Office Visit	$80	$120 no deductible	$140 no deductible	Not covered
Retail Health Clinic Visit	$40	$60 no deductible	$70 no deductible	Not covered
Telemedicine (through MDLive®)	$20 Fee	$20 Fee no deductible	$20 Fee no deductible	Not covered
Urgent Care Visit	$100	$100 no deductible	$100 no deductible	Not covered
Therapy Services	**Tier 1 - Preferred**	**Tier 2 - Enhanced**	**Tier 3 - Standard**	**Out-of-Network**
Physical Therapy (30 visits/year)[4]				
Freestanding	$80	$80 no deductible	$80 no deductible	Not covered
Hospital Based	$80	$80 no deductible	$80 no deductible	Not covered
Occupational Therapy (30 visits/year)[4]				
Freestanding	$80	$80 no deductible	$80 no deductible	Not covered

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Hospital Based	$80	$80 no deductible	$80 no deductible	Not covered
Speech Therapy (30 visits/year)	$80	$80 no deductible	$80 no deductible	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)	$550	$550 no deductible	$550 no deductible	Covered at In-Network level
Emergency Ambulance	$200	$200 no deductible	$200 no deductible	Covered at In-Network level
Non-Emergency Ambulance	$250	$250 no deductible	$250 no deductible	Not covered

Hospital Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Inpatient Hospital Services	$600/Day; max of 5 copays per admission	Subject to deductible and $900/Day; max of 5 copays per admission	Subject to deductible and $1,300/Day; max of 5 copays per admission	Not covered
Maternity Hospital Services	$600/Day; max of 5 copays per admission	Subject to deductible and $900/Day; max of 5 copays per admission	Subject to deductible and $1,300/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	5% after deductible	10% after deductible	Not covered

Outpatient Surgery	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Freestanding	$250	Subject to deductible and $750	Subject to deductible and $1,250	Not covered
Hospital Based	$250	Subject to deductible and $750	Subject to deductible and $1,250	Not covered
Outpatient Professional Services	No charge	5% after deductible	10% after deductible	Not covered

Outpatient Diagnostics	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Diagnostic Medical (EKG)	$120	$120 no deductible	$120 no deductible	Not covered
Routine Radiology (X-Ray)				
Freestanding	$120	$120 no deductible	$120 no deductible	Not covered
Hospital Based	$120	$120 no deductible	$120 no deductible	Not covered

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Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)				
Freestanding	$250	$250 no deductible	$250 no deductible	Not covered
Hospital Based	$250	$250 no deductible	$250 no deductible	Not covered

Outpatient Lab and Pathology	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Freestanding	No charge	No charge no deductible	No charge no deductible	Not covered
Hospital Based	No charge	No charge no deductible	No charge no deductible	Not covered

Other Medical Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Spinal Manipulations (20 visits/year)	$50	$50 no deductible	$50 no deductible	Not covered
Standard Injectables	30%	30% no deductible	30% no deductible	Not covered
Allergy Injections	30%	30% no deductible	30% no deductible	Not covered
Biotech/Specialty Injectables				
Home/Office	50%	50% no deductible	50% no deductible	Not covered
Outpatient	50%	50% no deductible	50% no deductible	Not covered
Chemotherapy	No charge	5% after deductible	10% after deductible	Not covered
Dialysis	$30	$90 no deductible	$150 no deductible	Not covered
Skilled Nursing Facility (120 days/year)	$300/Day; max of 5 copays per admission	$300/Day; max of 5 copays per admission no deductible	$300/Day; max of 5 copays per admission no deductible	Not covered
Home Health (60 visits/year)	No charge	5% after deductible	10% after deductible	Not covered
Hospice	No charge	No charge no deductible	No charge no deductible	Not covered
Durable Medical Equipment (DME)	50%	50% no deductible	50% no deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)	$80	$80 no deductible	$80 no deductible	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$600/Day; max of 5 copays per admission	$600/Day; max of 5 copays per admission no deductible	$600/Day; max of 5 copays per admission no deductible	Not covered

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[1] Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

[2] Out-of-pocket maximum is combined for all tiers.

[3] 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.

[4] 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**

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Drug Benefit Highlights

Keystone HMO Silver Proactive Rx

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$250/$500	$250/$500
Out-of-Pocket Maximum Individual/Family	Combined with Medical	Combined with Medical
Formulary[2]	Value	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$4 no deductible	30% Reimbursement no deductible
Tier 2 Generic Drugs	$15 no deductible	30% Reimbursement no deductible
Tier 3 Preferred Brand Drugs	50% up to $400 after deductible	30% Reimbursement after deductible
Tier 4 Non-Preferred Drugs	50% up to $500 after deductible	30% Reimbursement after deductible
Tier 5 Self-Administered Specialty Drugs	50% up to $1,000 after deductible	Not covered
Dispensing Limits[4]	30 day supply max	30 day supply max
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$8 no deductible	Not covered
Tier 2 Generic Drugs	$30 no deductible	Not covered
Tier 3 Preferred Brand Drugs	50% up to $800 after deductible	Not covered
Tier 4 Non-Preferred Drugs	50% up to $1,000 after deductible	Not covered
Tier 5 Self-Administered Specialty Drugs	Not covered	Not covered
Dispensing Limits[5]	90 day supply max	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs	Covered	Covered
Compound Medications	Covered	Covered
Contraceptives	Covered	Covered
Diabetic Supplies (i.e., test strips)	Covered	Covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Insulin	Covered	Covered

Reference ID: 1003156501012020

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Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Retin-A (up to Age 35)	Covered	Covered
Allergy Serum	Not 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] Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

[2] 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**.

[3] 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.

[4] 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.

[5] 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.

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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

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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-Network[1]	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-Network[1]**	**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-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	$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

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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	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	$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)	In-Network[1]	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
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).

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

Administered by Davis Vision.

Reference ID: 1003169601012020

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Reference ID: 1003169601012020

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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).

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

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**

Reference ID: 1003168001012020

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 કૉલ 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 schwetzscht, 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'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: 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 នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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: civilrightscoordinator@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*.