

Medical Benefit Highlights

Personal Choice PPO Silver Classic \$3,750/\$30/\$60/70%

| Covered Services | Your Costs (You pay) | |
|--|-------------------------|----------------------|
| Benefits per Contract Year | In-Network | Out-of-Network |
| Deductible (Embedded) ¹ Individual/Family | \$3,750/\$7,500 | \$8,500/\$17,000 |
| Out-of-Pocket Maximum (Embedded) ² Individual/Family | \$8,550/\$17,100 | \$25,000/\$50,000 |
| Coinsurance | 30% | 50% |
| Preventive Services | | |
| Preventive Care | No charge no deductible | 50% no deductible |
| Preventive Colonoscopy | | |
| Preventive Plus Providers | No charge no deductible | Not covered |
| Hospital Based | \$750 no deductible | 50% no deductible |
| Physician Services | | |
| Primary Care Physician (PCP) | | |
| Office Visit | \$30 no deductible | 50% after deductible |
| Telemedicine Visit | \$20 no deductible | 50% after deductible |
| Specialist | | |
| Office Visit | \$60 no deductible | 50% after deductible |
| Telemedicine Visit | \$40 no deductible | 50% after deductible |
| Retail Health Clinic Visit | \$30 no deductible | 50% after deductible |
| Urgent Care Visit | \$125 no deductible | 50% after deductible |
| Virtual Care³ | | |
| Telemedicine | No charge no deductible | Not covered |
| Teledermatology | No charge no deductible | Not covered |
| Telebehavioral Health | No charge no deductible | Not covered |
| Therapy Services | | |
| Physical Therapy (30 visits/year) ⁴ | | |
| Freestanding | \$60 no deductible | 50% after deductible |
| Hospital Based | \$90 no deductible | 50% after deductible |
| Occupational Therapy (30 visits/year) ⁴ | | |
| Freestanding | \$60 no deductible | 50% after deductible |
| Hospital Based | \$90 no deductible | 50% after deductible |
| Speech Therapy (30 visits/year) ⁵ | \$60 no deductible | 50% after deductible |

| | | |
|--|-------------------------|-----------------------------|
| Emergency Services | | |
| Emergency Room | 30% after deductible | Covered at In-Network level |
| Emergency Ambulance | 30% after deductible | Covered at In-Network level |
| Non-Emergency Ambulance | 30% after deductible | 50% after deductible |
| Hospital Services | | |
| Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁶ | 30% after deductible | 50% after deductible |
| Maternity Hospital Services ⁶ | 30% after deductible | 50% after deductible |
| Inpatient Professional Services (includes Maternity) | 30% after deductible | 50% after deductible |
| Outpatient Surgery | | |
| Freestanding | 30% after deductible | 50% after deductible |
| Hospital Based | 50% after deductible | 50% after deductible |
| Outpatient Professional Services | 30% after deductible | 50% after deductible |
| Outpatient Diagnostics | | |
| Diagnostic Medical (EKG) | 30% after deductible | 50% after deductible |
| Routine Radiology (X-Ray) | | |
| Freestanding | 30% after deductible | 50% after deductible |
| Hospital Based | 50% after deductible | 50% after deductible |
| Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan) | | |
| Freestanding | 30% after deductible | 50% after deductible |
| Hospital Based | 50% after deductible | 50% after deductible |
| Outpatient Lab and Pathology | | |
| Freestanding | No charge no deductible | 50% after deductible |
| Hospital Based | 50% after deductible | 50% after deductible |
| Other Medical Services | | |
| Spinal Manipulations (20 visits/year) ⁵ | \$60 no deductible | 50% after deductible |
| Acupuncture (18 visits/year) ⁵ | \$60 no deductible | 50% after deductible |
| Standard Injectables | No charge no deductible | 50% after deductible |
| Allergy Injections | No charge no deductible | 50% after deductible |
| Biotech/Specialty Injectables | | |
| Home/Office | \$100 no deductible | 50% after deductible |
| Outpatient | \$200 no deductible | 50% after deductible |
| Chemotherapy | 30% after deductible | 50% after deductible |
| Dialysis | 30% after deductible | 50% after deductible |
| Skilled Nursing Facility (120 days/year) ⁵ | 30% after deductible | 50% after deductible |

| | | |
|--|----------------------|----------------------|
| Home Health (60 visits/year) ⁵ | 30% after deductible | 50% after deductible |
| Hospice | 30% after deductible | 50% after deductible |
| Durable Medical Equipment (DME) | 50% after deductible | 50% after deductible |
| Mental Health – Outpatient (includes serious mental illness and substance abuse) | \$60 no deductible | 50% after deductible |
| Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁶ | 30% after deductible | 50% after deductible |

- 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 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 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.
- 4 Physical Therapy and Occupational Therapy combined visit limit in and out-of-network.
- 5 Combined in and out-of-network.
- 6 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

Personal Choice®, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing your care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

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 QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Drug Benefit Highlights

Personal Choice PPO Silver Classic Rx

Covered Services

Benefits per Contract Year

| |
|--|
| Deductible |
| Out-of-Pocket Maximum |
| 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 |
| Insulin |
| Insulin Needles and Syringes |
| Lancets |
| Prescribed Tobacco Cessation Drugs (RX and OTC) |
| Allergy Serum |
| Blood, Blood Plasma |
| Drugs used for Cosmetic Purposes |
| Injectable Fertility Drugs |
| Investigational/Experimental Drugs |

Your Costs (You pay)

In-Network

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

In-Network

| |
|-------------------|
| \$3 |
| \$20 |
| 50% up to \$125 |
| 50% up to \$250 |
| 50% up to \$1,000 |
| 30 day supply max |

In-Network

| |
|-------------------|
| \$6 |
| \$40 |
| 50% up to \$250 |
| 50% up to \$500 |
| Not covered |
| 90 day supply max |

In-Network

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

Out-of-Network

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

Out-of-Network

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

Out-of-Network

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

Out-of-Network

| |
|-------------|
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Covered |
| Not covered |
| Not covered |
| Not covered |
| 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 Rite Aid.

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.

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 Walgreens. 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 QCC Insurance Company, 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 PPO Stnd w/o Med Ded

PEDIATRIC BENEFITS

| Covered Services (Calendar Year) | Your Costs (You pay) | |
|---|---|----------------|
| Exam | In-Network | Out-of-Network |
| Routine Eye Exam at Davis Participating Providers (1 exam/year) | No charge | Not covered |
| Retinal Imaging | \$39 | Not covered |
| Lenses (1 pair/year) | In-Network | Out-of-Network |
| 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 | In-Network | Out-of-Network |
| Progressive Lenses - Standard/Premium/Ultra/Ultimate | \$50/\$90/\$140/\$175 | Not covered |
| Polycarbonate Lenses - Single/Multifocal ¹ | No charge | Not covered |
| Digital/Intermediate Lenses | \$30 | Not covered |
| Photochromic Lenses - Single/Multifocal | No charge | Not covered |
| Photosensitive Lenses - Single/Multifocal | \$65 | Not covered |
| High-Index 1.67 / High-Index 1.74 Lenses | \$55/\$120 | Not covered |
| Blue Light Lenses | \$15 | 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 - Single/Multifocal | No charge | Not covered |
| Scratch-Protection Plan - Single/Multifocal | \$20/\$40 | Not covered |
| Anti-Reflective Coating - Standard/Premium/Ultra/Ultimate | \$35/\$48/\$60/\$85 | Not covered |
| Frames (1 pair/year) | In-Network | Out-of-Network |
| Collection Fashion Frames | No charge | Not covered |
| Collection Designer Frames | No charge | Not covered |
| Collection Premier Frames | No charge | Not covered |
| Non-Collection Frames | Up to \$150 Allowance | Not covered |
| Additional Visionworks Frames Option | Up to \$150 Allowance (plus a 20% discount on overage) ² | Not covered |

| Contact Lenses (in lieu of glasses) (1 pair/year) | In-Network | Out-of-Network |
|---|---|-----------------------|
| Collection Contact Lenses Evaluation, Fitting & Follow-Up Care | No charge | Not covered |
| Collection Contact Lenses | Disposable Boxes/ Multipacks: 4 per year Planned Replacement Boxes/ Multipacks: 2 per year | Not covered |
| Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care | Not covered | Not covered |
| Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care | Not covered | Not covered |
| Non-Collection Contact Lenses | Up to \$150 Allowance | Not covered |
| Medically-Necessary Contact Lenses ³ | No charge | Not covered |

ADULT BENEFITS

| Covered Services (Calendar Year) | Your Costs (You pay) | |
|---|-----------------------------|-----------------------|
| Exam | In-Network | Out-of-Network |
| Routine Eye Exam at Davis Participating Providers (1 exam/year) | No charge | Not covered |
| Retinal Imaging | \$39 | Not covered |
| Lenses (1 pair/year) | In-Network | Out-of-Network |
| 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 | In-Network | Out-of-Network |
| Progressive Lenses - Standard/Premium/Ultra/Ultimate | \$65/\$105/\$140/\$175 | Not covered |
| Polycarbonate Lenses - Single/Multifocal ¹ | \$35 | Not covered |
| Digital/Intermediate Lenses | \$30 | Not covered |
| Photochromic Lenses - Single/Multifocal | No charge | Not covered |
| Photosensitive Lenses - Single/Multifocal | \$70 | Not covered |
| High-Index 1.67 / High-Index 1.74 Lenses | \$60/\$120 | Not covered |
| Blue Light Lenses | \$15 | 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 - Single/Multifocal | No charge | Not covered |
| Scratch-Protection Plan - Single/Multifocal | \$20/\$40 | Not covered |

| | | |
|--|---|-----------------------|
| Anti-Reflective Coating - Standard/Premium/ Ultra/Ultimate | \$40/\$55/\$69/\$85 | Not covered |
| Frames (1 pair/year) | In-Network | Out-of-Network |
| Collection Fashion Frames | No charge | Not covered |
| Collection Designer Frames | \$15 | Not covered |
| Collection Premier Frames | \$40 | Not covered |
| Non-Collection Frames | Up to \$130 Allowance (plus a 20% discount on overage) ² | Not covered |
| Additional Visionworks Frames Option | Up to \$180 Allowance (plus a 20% discount on overage) ² | Not covered |
| Contact Lenses (in lieu of glasses) (1 pair/ year) | In-Network | Out-of-Network |
| Collection Contact Lenses Evaluation, Fitting & Follow-Up Care | No charge | Not covered |
| Collection Contact Lenses | Disposable Boxes/ Multipacks: 4 per year Planned Replacement Boxes/ Multipacks: 2 per year | Not covered |
| Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care | Not covered | Not covered |
| Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care | Not covered | Not covered |
| Non-Collection Contact Lenses | Up to \$130 Allowance ² | Not covered |
| Medically-Necessary Contact Lenses ³ | No charge | Not covered |

- 1 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.
- 2 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.
- 3 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.

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Dental Benefit Highlights

Pediatric Dental SML PPO

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) | \$50 | 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 no deductible | Not covered |
| Basic Services | 50% after deductible | Not covered |
| Major Services | 50% after deductible | Not covered |
| Medically Necessary Orthodontics | 50% no deductible | Not covered |
| Cosmetic Orthodontic Services | Not covered | Not covered |
| Key Covered Services | In-Network | Out-of-Network |
| Exams | No charge no deductible | Not covered |
| Cleanings | No charge no deductible | Not covered |
| Bitewing X-rays | 50% no deductible | Not covered |
| Fluoride Treatments | No charge no deductible | Not covered |
| Sealants | No charge no deductible | Not covered |
| Basic Restorative (Fillings) | 50% after deductible | Not covered |
| Oral Surgery | 50% after deductible | Not covered |
| Endodontics | 50% after deductible | Not covered |
| Periodontics | 50% after deductible | Not covered |
| Crowns | 50% after deductible | Not covered |
| Bridges | 50% after deductible | Not covered |
| Dentures | 50% after deductible | 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>.