Independence

Medical Benefit Highlights

Keystone HMO Bronze Essential $7,500/$70/$140/$700

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**Referred**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual/Family	$7,500/$15,000	Not covered
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$9,200/$18,400	Not covered
Coinsurance	50%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	$750 no deductible	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$70 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered
Specialist		
Office Visit	$140 no deductible	Not covered
Telemedicine Visit	$95 no deductible	Not covered
Retail Health Clinic Visit	$70 no deductible	Not covered
Urgent Care Visit	$150 after deductible	Not covered
Virtual Care[3]	**Referred**	**Out-of-Network**
Telemedicine	No charge no deductible	Not covered
Teledermatology	No charge no deductible	Not covered
Telebehavioral Health	No charge no deductible	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[4]		
Freestanding	$140 no deductible	Not covered
Hospital Based	$140 no deductible	Not covered
Occupational Therapy (30 visits/year)[4]		
Freestanding	$140 no deductible	Not covered
Hospital Based	$140 no deductible	Not covered
Speech Therapy (30 visits/year)	$140 no deductible	Not covered

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Emergency Services	Referred	Out-of-Network
Emergency Room (copay waived if admitted)	$500 after deductible	Covered at In-Network level
Emergency Ambulance	$500 after deductible	Covered at In-Network level
Non-Emergency Ambulance	$500 no deductible	Not covered

Hospital Services	Referred	Out-of-Network
Inpatient Hospital Services	Subject to deductible and $700/ Day; max of 5 copays per admission	Not covered
Maternity Hospital Services	Subject to deductible and $700/ Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	50% after deductible	Not covered

Outpatient Surgery	Referred	Out-of-Network
Freestanding	$1,000 after deductible	Not covered
Hospital Based	$1,000 after deductible	Not covered
Outpatient Professional Services	$120 after deductible	Not covered

Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	$150 no deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	$150 no deductible	Not covered
Hospital Based	$150 no deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$350 no deductible	Not covered
Hospital Based	$350 no deductible	Not covered

Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered

Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (20 visits/year)	$140 no deductible	Not covered
Acupuncture (18 visits/year)	$140 no deductible	Not covered
Standard Injectables	No charge no deductible	Not covered
Allergy Injections	No charge no deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	$100 no deductible	Not covered
Outpatient	$100 no deductible	Not covered
Chemotherapy	$140 after deductible	Not covered

Dialysis	$140 no deductible	Not covered
Skilled Nursing Facility (120 days/year)	Subject to deductible and $350/ Day; max of 5 copays per admission	Not covered
Home Health (60 visits/year)	$325 no deductible	Not covered
Hospice	50% after deductible	Not covered
Durable Medical Equipment (DME)	50% after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$140 no deductible	Not covered
All Other Services	$140 no deductible	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	Subject to deductible and $700/ Day; max of 5 copays per admission	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 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.

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. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at **www.ibx.com**.

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**

Independence

Drug Benefit Highlights

Keystone HMO Bronze Essential $7,500/$70/$140/$700

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible	Medical deductible applies.	Medical deductible applies.
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Formulary[1]	Value	
Dispense as Written (DAW) Provision[2]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$7 no deductible	30% Reimbursement no deductible
Tier 2 Generic Drugs	$30 after deductible	30% Reimbursement after deductible
Tier 3 Preferred Brand Drugs	50% up to $500 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% after deductible	Not covered
Dispensing Limits[3,4]	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	$14 no deductible	Not covered
Tier 2 Generic Drugs	$60 after deductible	Not covered
Tier 3 Preferred Brand Drugs	50% up to $1,000 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	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	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Allergy Serum	Not covered	Not covered

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Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Investigational/Experimental 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 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).

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

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 Preferred Pharmacy Network. The 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.

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Independence

Vision Benefit Highlights

Pediatric/Adult Vision SML HMO/POS 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

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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	No charge	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to $60 Allowance	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

Independence

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	No charge	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to $60 Allowance	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, an Independent Company.

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**

Independence

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: 1005832901012025

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.

Telugu: శ్రద్ధ పెట్టం డి: ఒకవేళ మీరు తెలుగు భాష మాట్లా డుతున్న ట్టయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిన్న యి. 1-800-275-2583 (TTY: 711) కు కాల చేయండి.

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។

Taglines as of 12/31/2022

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*.