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 (Embedded)[2]				
Individual/Family		$9,800/$19,600		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	$70 no deductible	$80 no deductible	Not covered
Telemedicine Visit	$30	$50 no deductible	$55 no deductible	Not covered
Specialist				
Office Visit	$90	$140 no deductible	$150 no deductible	Not covered
Telemedicine Visit	$65	$100 no deductible	$105 no deductible	Not covered
Retail Health Clinic Visit	$40	$70 no deductible	$80 no deductible	Not covered
Urgent Care Visit	$90	$90 no deductible	$90 no deductible	Not covered
Virtual Care[3]	**Tier 1 - Preferred**	**Tier 2 - Enhanced**	**Tier 3 - Standard**	**Out-of-Network**
Telemedicine	No charge	No charge no deductible	No charge no deductible	Not covered
Teledermatology	No charge	No charge no deductible	No charge no deductible	Not covered

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Telebehavioral Health	No charge	No charge no deductible	No charge 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	$90	$90 no deductible	$90 no deductible	Not covered
Hospital Based	$90	$90 no deductible	$90 no deductible	Not covered
Occupational Therapy (30 visits/year)[4]				
Freestanding	$90	$90 no deductible	$90 no deductible	Not covered
Hospital Based	$90	$90 no deductible	$90 no deductible	Not covered
Speech Therapy (30 visits/year)	$90	$90 no deductible	$90 no deductible	Not covered

Emergency Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Emergency Room (copay waived if admitted)	$950	$950 no deductible	$950 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

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Outpatient Professional Services	$5	$15 after deductible	$25 after deductible	Not covered

Outpatient Diagnostics	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Diagnostic Medical (EKG)	$150	$150 no deductible	$150 no deductible	Not covered
Routine Radiology (X-Ray)				
Freestanding	$150	$150 no deductible	$150 no deductible	Not covered
Hospital Based	$150	$150 no deductible	$150 no deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)				
Freestanding	$375	$375 no deductible	$375 no deductible	Not covered
Hospital Based	$375	$375 no deductible	$375 no deductible	Not covered

Outpatient Lab and Pathology	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Freestanding	$15	$15 no deductible	$15 no deductible	Not covered
Hospital Based	$15	$15 no deductible	$15 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
Acupuncture (18 visits/year)	$50	$50 no deductible	$50 no deductible	Not covered
Standard Injectables	$90	$90 no deductible	$90 no deductible	Not covered
Allergy Injections	$90	$90 no deductible	$90 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	$200 no deductible	$250 no deductible	Not covered
Hospice	No charge	No charge no deductible	No charge no deductible	Not covered

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Durable Medical Equipment (DME)	50%	50% no deductible	50% no deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)				
Office Visit	$90	$90 no deductible	$90 no deductible	Not covered
All Other Services	$90	$90 no deductible	$90 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

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 Silver Proactive

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$225/$450	
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Formulary[2]	Value	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy (per 30 day supply)	**In-Network**	**Out-of-Network**
Tier 1 Low-Cost Generic Drugs	$7 no deductible	30% Reimbursement no deductible
Tier 2 Generic Drugs	$30 no deductible	30% Reimbursement no deductible
Tier 3 Preferred Brand Drugs	$125 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[4,5]	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 no deductible	Not covered
Tier 3 Preferred Brand Drugs	$250 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

Reference ID: 1006613301012026

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Allergy Serum	Not covered	Not covered
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 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 designated pharmacies or mail for same cost share..

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

Independence

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.

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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

Benefit Enhancement	**In-Network**	**Out-of-Network**
Preventive Rewards	Not covered	Not covered
Rollover	Not covered	Not covered
Rollover Threshold	Not covered	Not covered
Rollover Max	Not covered	Not covered

Independence

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.

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Reference ID: 1006650101012026

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 3852-572-008-1 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意：如果您说普通话，我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务，确保以无障碍格式传递信息。请致电 1-800-275-2583（TTY：711）或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ़्त में उपलब्ध हैं। सुलभ फ़ॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ़्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어를: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjį' bee adahodooníłí diné bich'į' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígíí ałdó' t'áá jiik'eh hǫlǫ́. Kohjį' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'į' hanidziih.

Pennsilfaanisch-Deitsch: WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్‌కు కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtìlẹhin èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna irááyèsi kíka wà lárọwọ́tó bakanna lọ́fẹ̀ẹ́. Pe 1-800-275-2583 (TTY: 711) tàbi ki ó bá olùpèsè rẹ sọ̀rọ̀.

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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com.**

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at the following website**:** **www.healthinsurancehosting.com/notices**.

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