Independence

# Medical Benefit Highlights

## Personal Choice PPO Gold Preferred $40/$80/$600

| Covered Services | Your Costs (You pay) | |
|---|---|---|
| **Benefits per Contract Year** | **In-Network** | **Out-of-Network** |
| Deductible (Embedded)[1] Individual/Family | $0/$0 | $7,000/$14,000 |
| Out-of-Pocket Maximum (Embedded)[2] Individual/Family | $8,800/$17,600 | $21,000/$42,000 |
| Coinsurance | 0% | 50% |
| **Preventive Services** | **In-Network** | **Out-of-Network** |
| Preventive Care | No charge | 50% no deductible |
| Preventive Colonoscopy | | |
| Preventive Plus Providers | No charge | Not covered |
| Hospital Based | $750 | 50% no deductible |
| **Physician Services** | **In-Network** | **Out-of-Network** |
| Primary Care Physician (PCP) | | |
| Office Visit | $40 | 50% after deductible |
| Telemedicine Visit | $30 | 50% after deductible |
| Specialist | | |
| Office Visit | $80 | 50% after deductible |
| Telemedicine Visit | $55 | 50% after deductible |
| Retail Health Clinic Visit | $40 | 50% after deductible |
| Urgent Care Visit | $100 | 50% after deductible |
| **Virtual Care[3]** | **In-Network** | **Out-of-Network** |
| Telemedicine | No charge | Not covered |
| Teledermatology | No charge | Not covered |
| Telebehavioral Health | No charge | Not covered |
| **Therapy Services** | **In-Network** | **Out-of-Network** |
| Physical Therapy (30 visits/year)[4] | | |
| Freestanding | $80 | 50% after deductible |
| Hospital Based | $110 | 50% after deductible |
| Occupational Therapy (30 visits/year)[4] | | |
| Freestanding | $80 | 50% after deductible |
| Hospital Based | $110 | 50% after deductible |
| Speech Therapy (30 visits/year)[5] | $80 | 50% after deductible |

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| Emergency Services | In-Network | Out-of-Network |
|---|---|---|
| Emergency Room (copay waived if admitted) | $500 | Covered at In-Network level |
| Emergency Ambulance | $75 | Covered at In-Network level |
| Non-Emergency Ambulance | $75 | 50% after deductible |

| Hospital Services | In-Network | Out-of-Network |
|---|---|---|
| Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6] | $600/Day; max of 5 copays per admission | 50% after deductible |
| Maternity Hospital Services[6] | $600/Day; max of 5 copays per admission | 50% after deductible |
| Inpatient Professional Services (includes Maternity) | No charge | 50% after deductible |

| Outpatient Surgery | In-Network | Out-of-Network |
|---|---|---|
| Freestanding | $300 | 50% after deductible |
| Hospital Based | $700 | 50% after deductible |
| Outpatient Professional Services | No charge | 50% after deductible |

| Outpatient Diagnostics | In-Network | Out-of-Network |
|---|---|---|
| Diagnostic Medical (EKG) | $70 | 50% after deductible |
| Routine Radiology (X-Ray) | | |
| Freestanding | $70 | 50% after deductible |
| Hospital Based | $175 | 50% after deductible |
| Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan) | | |
| Freestanding | $150 | 50% after deductible |
| Hospital Based | $300 | 50% after deductible |

| Outpatient Lab and Pathology | In-Network | Out-of-Network |
|---|---|---|
| Freestanding | $10 | 50% after deductible |
| Hospital Based | $75 | 50% after deductible |

| Other Medical Services | In-Network | Out-of-Network |
|---|---|---|
| Spinal Manipulations (20 visits/year)[5] | $80 | 50% after deductible |
| Acupuncture (18 visits/year)[5] | $80 | 50% after deductible |
| Standard Injectables | No charge | 50% after deductible |
| Allergy Injections | No charge | 50% after deductible |
| Biotech/Specialty Injectables | | |
| Home/Office | $125 | 50% after deductible |
| Outpatient | $250 | 50% after deductible |
| Chemotherapy | $80 | 50% after deductible |
| Dialysis | $80 | 50% after deductible |

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|---|---|---|
| Skilled Nursing Facility (120 days/year)[5] | $300/Day; max of 5 copays per admission | 50% after deductible |
| Home Health (60 visits/year)[5] | $80 | 50% after deductible |
| Hospice | No charge | 50% after deductible |
| Durable Medical Equipment (DME) | 50% | 50% after deductible |
| Mental Health – Outpatient (includes serious mental illness and substance abuse) | | |
| Office Visit | $80 | 50% after deductible |
| All Other Services | $80 | 50% after deductible |
| Mental Health – Inpatient (includes serious mental illness and substance abuse)[6] | $600/Day; max of 5 copays per admission | 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/SGIACBooklet** 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.

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# Drug Benefit Highlights

## Personal Choice PPO Gold Preferred $40/$80/$600

| Covered Services | Your Costs (You pay) | |
|---|---|---|
| **Benefits per Contract Year** | **In-Network** | **Out-of-Network** |
| Deductible | $0/$0 | $0/$0 |
| Out-of-Pocket Maximum | Combined with Medical | Combined with Medical |
| Formulary[1] | Value | |
| **Retail Pharmacy (per 30 day supply)** | **In-Network** | **Out-of-Network** |
| Tier 1 Low-Cost Generic Drugs | $3 | 30% Reimbursement |
| Tier 2 Generic Drugs | $15 | 30% Reimbursement |
| Tier 3 Preferred Brand Drugs | $85 | 30% Reimbursement |
| Tier 4 Non-Preferred Drugs | $200 | 30% Reimbursement |
| Tier 5 Self-Administered Specialty Drugs | 50% up to $1,000 | Not covered |
| Dispensing Limits[2,3] | 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 | $6 | Not covered |
| Tier 2 Generic Drugs | $30 | Not covered |
| Tier 3 Preferred Brand Drugs | $170 | Not covered |
| Tier 4 Non-Preferred Drugs | $400 | 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 |
| 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 |

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|---|---|---|
| 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 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.

3 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/SGIACBooklet** 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 pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.

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# Vision Benefit Highlights

## Pediatric/Adult Vision SML PPO Stnd Med $0

### 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] | $35 | Not covered |
| Digital/Intermediate Lenses | $30 | Not covered |
| Photochromic Lenses - Single/Multifocal | $5 | Not covered |
| Photosensitive Lenses - Single/Multifocal | $70 | 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 | $5 | 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 | Not covered | 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<br>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 | $5 | 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 | $5 | Not covered |
| Scratch-Protection Plan - Single/Multifocal | $20/$40 | Not covered |

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| | | |
|---|---|---|
| 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/SGIACBooklet** 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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# 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 |

| 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 |

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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/SGIACBooklet** 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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# 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.

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## 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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