

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		
Preventive Care	No charge	50% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	\$750	50% no deductible
Physician Services		
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 Care³		
Telemedicine	No charge	Not covered
Teledermatology	No charge	Not covered
Telebehavioral Health	No charge	Not covered
Therapy Services		
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

Emergency Services

Emergency Room (copay waived if admitted)
Emergency Ambulance
Non-Emergency Ambulance

In-Network

\$500
\$75
\$75

Out-of-Network

Covered at In-Network level
Covered at In-Network level
50% after deductible

Hospital Services

Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁶
Maternity Hospital Services ⁶
Inpatient Professional Services (includes Maternity)

In-Network

\$600/Day; max of 5 copays per admission
\$600/Day; max of 5 copays per admission
No charge

Out-of-Network

50% after deductible
50% after deductible
50% after deductible

Outpatient Surgery

Freestanding
Hospital Based
Outpatient Professional Services

In-Network

\$300
\$700
No charge

Out-of-Network

50% after deductible
50% after deductible
50% after deductible

Outpatient Diagnostics

Diagnostic Medical (EKG)
Routine Radiology (X-Ray)
Freestanding
Hospital Based
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)
Freestanding
Hospital Based

In-Network

\$70
\$70
\$175
\$150
\$300

Out-of-Network

50% after deductible
50% after deductible
50% after deductible
50% after deductible
50% after deductible

Outpatient Lab and Pathology

Freestanding
Hospital Based

In-Network

\$10
\$75

Out-of-Network

50% after deductible
50% after deductible

Other Medical Services

Spinal Manipulations (20 visits/year) ⁵
Acupuncture (18 visits/year) ⁵
Standard Injectables
Allergy Injections
Biotech/Specialty Injectables
Home/Office
Outpatient
Chemotherapy
Dialysis

In-Network

\$80
\$80
No charge
No charge
\$125
\$250
\$80
\$80

Out-of-Network

50% after deductible
50% after deductible
50% after deductible
50% after deductible
50% after deductible
50% after deductible
50% after deductible
50% after deductible

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.

Benefits underwritten or administered by Independence Assurance 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 Gold Preferred \$40/\$80/\$600

Covered Services

Benefits per Contract Year

Deductible
Out-of-Pocket Maximum
Formulary ¹

Retail Pharmacy (per 30 day supply)

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 ^{2,3}

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

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
Non-Federal Legend Drugs

Your Costs (You pay)

In-Network

\$0/\$0
Combined with Medical Value

In-Network

\$3
\$15
\$85
\$200
50% up to \$1,000
30 day supply max

In-Network

\$6
\$30
\$170
\$400
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
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
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 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 preventative 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

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	\$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

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



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).

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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 مجاناً لضمان وصول المعلومات إليك بصيغ ميسرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (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 fòm aksèsib 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 કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ्त में उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ्त 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。

한국어: 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 yánílti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjí' bee adahodooníí diné bich'í' anídahazt'í'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaígíí áldó' t'áá jiik'eh hóló. Kohjí' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'í' hanidziih.

Pennsilfaanisch-Deutsch: WICHDICH: Wann du Deutsch 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) నంబర్ కు కాల్ చేయండి లేదా మీ ప్రొవైడర్ తో 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 nso Yorùbá, àwọn isẹ̀ àtilẹ̀hin èdè lófẹ̀ẹ̀ wà lárọ̀wọ̀tó rẹ. Àwọn isẹ̀ àtilẹ̀hin irànlọ̀wọ̀ tó yẹ láti pèsè iwífúnni ní ọ̀na irááyèsì kíkà wà lárọ̀wọ̀tó bakanna lófẹ̀ẹ̀. Pẹ 1-800-275-2583 (TTY: 711) tàbí kí ó bá olùpèsè rẹ sọrọ.

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.