Independence

Medical Benefit Highlights

The Preferred Provider Organization Tier 2 Devereux IND/FAM

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual/Family	$800/$1,600	Not covered
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$4,380/$8,760	Not covered
Coinsurance	20%	Not covered
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$25 no deductible	Not covered
Telemedicine Visit	$25 no deductible	Not covered
Specialist		
Office Visit	$50 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered
Retail Health Clinic Visit	$25 no deductible	Not covered
Urgent Care Visit	$50 no deductible	Not covered
Virtual Care[3]	**In-Network**	**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	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Occupational Therapy (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Speech Therapy (60 visits/year)[4]	$40 no deductible	Not covered

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Emergency Services	In-Network	Out-of-Network
Emergency Room (copay waived if admitted)	$300 no deductible	Covered at In-Network level
Emergency Ambulance	20% after deductible	Covered at In-Network level
Non-Emergency Ambulance	20% after deductible	Not covered

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services	$250/Admission after deductible, then 20%	Not covered
Observation Services	20% after deductible	Not covered
Maternity Hospital Services	$250/Admission after deductible, then 20%	Not covered
Inpatient Professional Services (includes Maternity)	20% after deductible	Not covered

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	20% after deductible	Not covered
Hospital Based	20% after deductible	Not covered
Outpatient Professional Services	20% after deductible	Not covered

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	20% after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	20% after deductible	Not covered
Hospital Based	20% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$100 after deductible, then 20%	Not covered
Hospital Based	$100 after deductible, then 20%	Not covered

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

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (15 visits/year)	$40 no deductible	Not covered
Acupuncture (18 visits/year)	$50 no deductible	Not covered
Standard Injectables	20% after deductible	Not covered
Allergy Injections	No charge no deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	20% after deductible	Not covered
Outpatient	20% after deductible	Not covered
Chemotherapy	20% after deductible	Not covered

Dialysis	20% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	20% after deductible	Not covered
Home Health	20% after deductible	Not covered
Hospice	20% after deductible	Not covered
Durable Medical Equipment (DME)	No charge after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$20 no deductible	50% after deductible
All Other Services	$20 no deductible	50% after deductible
Telemedicine Visit	No charge no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)	No charge after deductible	50% after deductible

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

3 Telemedicine is provided by a designated telemedicine provider, please visit **www.ibx.com/findcarenow**.

4 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit.

The EPO Program provides in-network-only benefits through the Personal Choice® or BlueCard® PPO networks. Except for emergency services, all care must be received from participating Personal Choice network or BlueCard PPO network providers. There is no benefit coverage for care received from non-preferred, non-participating providers.

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/LGIACBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

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

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.ibx.com/preapproval** or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Drug Benefit Highlights

Freestanding Premium 15%/35%50% IND/FAM

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/Family	$4,830/$9,660	Not covered
Formulary[2]	Premium	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy (per 30 day supply)	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits[4,7]	90 day supply max	Not covered
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits	100 day supply max	Not covered
Mandatory Mail for Maintenance Drugs[5]	Yes	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[6]	Covered	Not covered
Compound Medications	Covered	Not covered
Contraceptives	Covered	Not covered
Diabetic Supplies (i.e., test strips)	Covered	Not covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Insulin	Covered	Not covered
Insulin Needles and Syringes	Covered	Not covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Not covered
Allergy Serum	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 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, 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 CVS90 Saver Plus - 90-day supply of drugs to treat chronic conditions must be obtained at CVS or mail for same cost share, except first two fills may be 30-day fills obtained at any participating retail pharmacy.

5 All covered medications for chronic conditions (such as blood pressure medications) will be provided through our convenient mail order service, which allows you to order up to a 100-day supply. This benefit can save you time and money. If your doctor wants you to start the drug immediately, your 2 fill supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through our convenient mail order service. Member cost sharing is indicated above.

6 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.

7 A 90-day supply at retail is 3 times the 30-day 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/LGIACBooklet** 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.

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.

All covered self-administered specialty medications will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. If your doctor wants you to start the drug immediately, an initial 30-day supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through the Specialty Pharmacy Program.

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.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Vision Benefit Highlights

Devereux Vision Care 130: 12/12/12

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers (1 exam/year)[1]	No charge	$40 Reimbursement
Retinal Imaging	$39	Not covered
Lenses (1 pair/year)[1]	**In-Network**	**Out-of-Network[2]**
Single Vision Lenses	No charge	$40 Reimbursement
Bifocal Lenses	No charge	$60 Reimbursement
Trifocal Lenses	No charge	$80 Reimbursement
Lenticular Lenses	No charge	$100 Reimbursement
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/ Ultimate	$50/$90/$140/$175	$60 Reimbursement
Polycarbonate Lenses - Single/Multifocal[3]	$30	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 Coating - 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)[1]	**In-Network**	**Out-of-Network**
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	No charge	Not covered
Collection Premier Frames	$25	Not covered
Non-Collection Frames	Up to $130 Allowance (plus a 20% discount on overage)	$50 Reimbursement
Visionworks Frames Option	Up to $180 Allowance (plus a 20% discount on overage)[4]	Not covered

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Contact Lenses (in lieu of glasses) (1 pair/ year)[1]	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	Up to $60 Allowance[4]	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to $60 Allowance[4]	Not covered
Non-Collection Contact Lenses	Up to $130 Allowance[4]	$105 Reimbursement
Medically-Necessary Contact Lenses[5]	No charge	$225 Reimbursement

1 Combined in and out-of-network.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

4 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

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

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 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 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 àtìlẹhìn èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna iráàyèsi 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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