This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ibx.com or by calling 1-800-ASK-BLUE.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers $1,500 person / $3,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-ASK-BLUE or visit us at www.ibx.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.ibx.com or call 1-800-ASK-BLUE to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	Not Covered	----------none----------
	Specialist visit	$35 copayment	Not Covered	PCP referral required.
	Other practitioner office visit	Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement	Not Covered	Spinal Manipulations covered up to 60 consecutive visits per benefit period subject to significant improvement. PCP referral required.
	Preventive care / screening / immunization	No Charge	Not Covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Precertification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/preapproval	Generic drugs	$20 Copayment (Retail)/$20 Copayment (1-30 days supply)(Mail Order); $40 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Preferred brand drugs	$40 Copayment (Retail)/$40 Copayment (1-30 days supply)(Mail Order); $80 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
	Non-preferred brand drugs	$60 Copayment (Retail)/$60 Copayment (1-30 days supply)(Mail Order); $120 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Specialty drugs	Covered No Charge	Not Covered	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self-administered specialty drugs follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior-authorization required. A complete list of drugs requiring prior-authorization is available at www.ibx.com/preapproval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 Copayment	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval
	Physician/surgeon fees	Not Covered	Not Covered	----------none----------
If you need immediate medical attention	Emergency room services	Covered with a $150 copayment	Covered with a $150 copayment	Your costs for Emergency Room services are waived if you are admitted to the hospital.
	Emergency medical transportation	Covered No Charge when medically necessary	Covered No Charge when medically necessary	----------none----------
	Urgent care	$105 Copayment	Not Covered	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment/admission	Not Covered	Precertification required.
	Physician/surgeon fee	No Charge	Not Covered	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	----------none----------
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	----------none----------
	Substance abuse disorder outpatient services	Not Covered	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
	Substance abuse disorder inpatient services	Not Covered	Not Covered	----------none----------
If you are pregnant	Prenatal and postnatal care	Covered with a $35 copayment for the first visit. Subsequent visits to your OB/GYN covered No Charge. Inpatient care covered with a $100 copayment per admission	Not Covered	Your cost is for first OB visit only.
	Delivery and all inpatient services	No Charge	Not Covered	Pre-notification requested.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Precertification required.
	Rehabilitation services	Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement	Not Covered	Speech/Physical/Occupational: Up to 60 consecutive days per condition covered, subject to significant improvement. PCP referral required.
	Habilitation services	Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement	Not Covered	Speech/Physical/Occupational: Up to 60 consecutive days per condition covered, subject to significant improvement. PCP referral required.
	Skilled nursing care	Covered No Charge up to 180 days per calendar year	Not Covered	Precertification required.
	Durable medical equipment	All purchases and rentals (including repairs and replacements) are covered No Charge	Not Covered	Precertification required for selected items. A complete list is available at www.ibx.com/preapproval.
	Hospice service	No Charge	Not Covered	----------none----------
If your child needs dental or eye care	Eye exam	Covered	Not Covered	Once every two calendar years
	Glasses	Covered	Not Covered	Once every two calendar years
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment (See Benefit Booklet/Member handbook for limitations)
- Long-term care
- Non-emergency care when traveling outside the U.S. (For details, see www.ibx.com)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium,which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-671-5276.You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays** $7,370
- **Patient Pays** $170

Sample Care Costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	$170

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays** $3,570
- **Patient Pays** $1,830

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays

Deductibles	$0
Copays	$1,750
Coinsurance	$0
Limits or exclusions	$80
Total	$1,830

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔Yes. An important cost is the premium you pay. Generally, the lower your premium,the more you'll pay in out-of-pocket costs, such as copayments, deductibles and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts(HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-ASK-BLUE or visit us at www.ibx.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ibx.com or call 1-800-ASK-BLUE to request a copy.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal

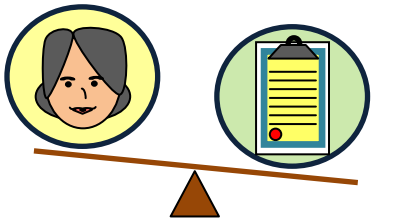
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

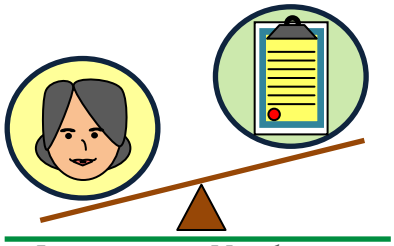
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

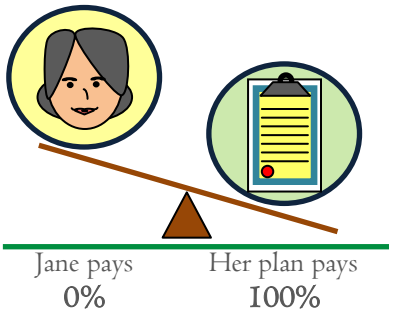
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

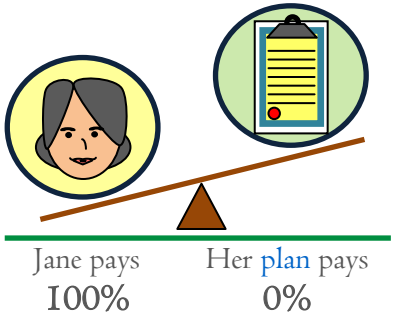
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

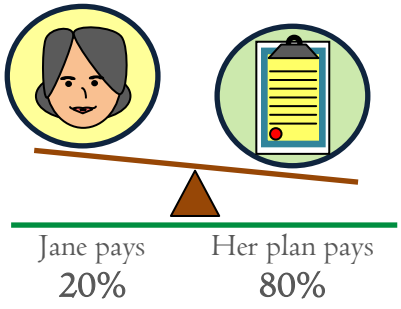


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

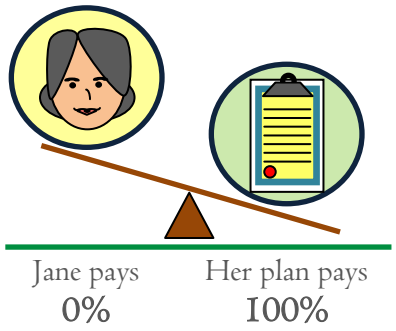


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Language Access Services

If you, or someone you're helping, has questions about Independence Blue Cross, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-275-2583 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independence Blue Cross, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-275-2583 TTY 711.

如对 Independence Blue Cross 有任何问题，请您或您所帮助的人联系我们提供的免费多语言信息服务。翻译服务请拨打 1-800-275-2583。

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về Independence Blue Cross, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-800-275-2583.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы Independence Blue Cross, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-275-2583.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Independence Blue Cross, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-275-2583 uffrufe.

Independence Blue Cross 와 관련하여 궁금한 사항이 있으신 경우, 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-800-275-2583 로 전화해 주십시오.

Se tu o qualcuno che stai aiutando avete domande su Independence Blue Cross, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-800-275-2583.

إذا كان لديك أو لدى شخص تساعده أسئلة بخصوص Independence Blue Cross، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-800-275-2583.

Si vous, ou quelqu'un que vous aidez, a des questions à propos d'Independence Blue Cross, vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-800-275-2583.

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über Independence Blue Cross haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-275-2583 an.

જો તમને અથવા તમે કોઇને મદદ કરી રહ્યા તેમાંથી કોઇને Independence Blue Cross વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-800-275-2583 પર કોલ કરો

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu Independence Blue Cross, mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-800-275-2583.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan Independence Blue Cross, ou gen dwa pou resevwa èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-275-2583.

បើអ្នក ឬក៏នរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Independence Blue Cross អ្នកមានសិទ្ធិក្នុងការទទួលជំនួយនិង ព័ត៌មានជាភាសារបស់អ្នក ដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅទូរសព្ទទៅលេខ 1-800-275-2583។.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Independence Blue Cross, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-275-2583.

Díí kwe'é atah nílínígíí Independence Blue Cross haada yit'éego bína ídíłkidgo éi doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo bee ná ahóót'i'díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 1-800-275-2583.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa Independence Blue Cross, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-800-275-2583.

ご本人やお客様の周りの人が、Independence Blue Cross についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用する方は、1-800-275-2583 までお電話ください。

اگر شما یا شخصی که به وی کمک می کنید، در رابطه با Independence Blue Cross سوالی دارید، این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-800-275-2583 تماس حاصل فرمایید.

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

Independence Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Blue Cross:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator. If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have five ways to file a grievance:

- In person or by mail :
  Independence Blue Cross
  ATTN: Civil Rights Coordinator
  1901 Market Street
  Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY 711)
- By fax: 215-761-0245
- By email: civilrightscoordinator@ibx.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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