Application for Group Coverage

Thank you for applying for coverage from Independence Blue Cross (IBX).
Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Your Group Administrator must complete Section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

PPO	HMO	POS	DPOS
Rx	Vision	Dental	MedigapSecurity

3. Provide information about your spouse/domestic partner and dependents only if they are also applying for coverage (Section 4). If you need more space, attach an additional application with your signature and date. Important: You must include a Relationship Code (listed at the bottom of pages 3 through 7) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Section 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 8. Once you have completed and signed your application, be sure to make a copy for your records.

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

The collection of Race, Ethnicity, and Language data is confidential and voluntary. We are collecting this information as part of our efforts to support equitable, whole-person coverage. The information regarding demographic factors: (1) will be maintained as private; (2) may not be used by the insurer for eligibility determinations, underwriting, or rating purposes; and (3) the insurer will not deny an application based on the applicant's refusal to answer the questions related to demographic data. This data may be analyzed by our data analysts to support equitable, whole-person health initiatives. For information about the Plan's policies and procedures for managing access to and use of Race, Ethnicity, and Language data, including controls for physical and electronic access to the data, permissible use of the data, and impermissible use of the data, please refer to the Notice of Privacy Practices at ibx.com/privacy.

If you have any questions or need help completing this application, contact IBX at 1-800-ASK-BLUE (1-800-275-2583) (TTY:711), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684 (TTY:711), Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the IBX family!

Universal Enrollment Form

SECTION 1 — Subscriber or member enrollment or change

Employee MUST complete in full

Type of coverage	Change	Reason for application	Other change
☐ Employee only ☐ Employee and child ☐ Employee and children ☐ Employee and spouse or domestic partner ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Primary dental office	☐ Add spouse/domestic partner ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date: (mm/dd/yy) ____/____/____	☐ COBRA effective date: (mm/dd/yy) ____/____/____ Effective date of coverage: ____/____/____ mm dd yy

SECTION 2 — To be completed by Group Administrator

Plan – specify sub-account and BPID:				Employment status:	Terminate contract
PPO	HMO	POS	DPOS	☐ Active ☐ Retiree	☐ Terminated employment ☐ Full-time to part-time ☐ Deceased. Indicate date. ____/____/____
Rx	Vision	Dental		☐ MedigapSecurity	☐ Other (please explain) _____

SECTION 3 — Subscriber information

Complete this entire section, whether you are a new applicant or are making a change to an existing contract.

Social Security number or ID number	Last name	Middle initial	First name

Sex assigned at birth:	Date of birth	Street address	Apt or suite
☐ M ☐ F ☐ Other ☐ Prefer not to answer	____/____/____		

City	State	ZIP code	Date of hire
			/ /

Telephone number (including area code)	Primary care physician provider ID (HMO ID#, HMO/POS/DPOS only)*	Primary care office name (HMO ID#, HMO/POS/DPOS only)*
Home ( )		☐ Check if current patient
Work ( )	Provider NPI number	Primary care office address
Mobile ( )	By providing my phone number and/or email address, I authorize Independence Blue Cross, its subsidiaries and affiliates (collectively "Independence"), and my employer to contact me via email, automated text and/or phone call. I understand that my consent is not a condition of any benefit or purchase. Message and data rates may apply. To view the communication preferences terms and conditions, please visit ibx.com/communications.	
Email address		

* A primary care physician (PCP) code and primary dental office are required for all HMO/POS/DPOS medical and dental plans.
Visit ibx.com/providerfinder to find a primary care physician (PCP) or a primary dental office.
You can also call 215-241-CARE (2273) to request a PCP directory (HMO/POS/DPOS plans only.).

SECTION 3 — Subscriber information (continued)

Racial identity (select all that apply)†

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural identity (select up to 5)

☐ Cherokee ☐ Asian Indian ☐ African ☐ Guamanian or Chamorro ☐ English ☐ Cuban
☐ Nanticoke Lenni-Lenape ☐ Chinese ☐ Haitian ☐ Micronesian ☐ German ☐ Dominican (Dominican Republic)
☐ Navajo ☐ Filipino ☐ Jamaican ☐ Native Hawaiian ☐ Irish ☐ Guatemalan
☐ Powhatan Renape Nation ☐ Korean ☐ Nigerian ☐ Polynesian ☐ Italian ☐ Mexican
☐ Ramapough Lenape Indian Nation ☐ Vietnamese ☐ West Indian ☐ Samoan ☐ Polish ☐ Puerto Rican
☐ Other ☐ Prefer not to answer

SECTION 4 — Family information (if applying)‡

Spouse/Domestic partner name: (last, first, middle initial) | Social Security number

Employer name | Birth date (mm/dd/yy) ___/___/___ | Age ___ | Sex assigned at birth: ☐ M ☐ F ☐ Other ☐ Prefer not to answer | Relationship Code:§ ___

Racial identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

†The information regarding demographic factors: (1) will be maintained as private; (2) may not be used by the insurer for eligibility determinations, underwriting, or rating purposes; and (3) the insurer will not deny an application based on the applicant's refusal to answer the questions related to demographic data.

‡If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

§Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)

Preferred language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural identity (select up to 5)

☐ Cherokee ☐ Asian Indian ☐ African ☐ Guamanian or Chamorro ☐ English ☐ Cuban
☐ Nanticoke Lenni-Lenape ☐ Chinese ☐ Haitian ☐ Micronesian ☐ German ☐ Dominican (Dominican Republic)
☐ Navajo ☐ Filipino ☐ Jamaican ☐ Native Hawaiian ☐ Irish ☐ Guatemalan
☐ Powhatan Renape Nation ☐ Korean ☐ Nigerian ☐ Polynesian ☐ Italian ☐ Mexican
☐ Ramapough Lenape Indian Nation ☐ Vietnamese ☐ West Indian ☐ Samoan ☐ Polish ☐ Puerto Rican
☐ Other ☐ Prefer not to answer

Primary care physician provider ID# (HMO ID#, HMO/POS/DPOS only)‡	Primary care office/PCP name (HMO/POS/DPOS only)‡
Provider NPI number	Primary care office address
Current patient of PCP? (HMO/POS/DPOS only)‡ ☐ Yes ☐ No	Primary dental office ID#

Dependent¶ name: (last, first, middle initial)				Social Security number
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) / /	Age	Sex assigned at birth: ☐ M ☐ F ☐ Other ☐ Prefer not to answer	Relationship code:§

Racial identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

‡A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Visit ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a PDO from the Plan's dental HMO network. The member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.
You can also call 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS plans only).

¶Children younger than 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

§Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)

Ethnic identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

☐ Unknown ☐ Prefer not to answer

Preferred language

☐ English ☐ Spanish ☐ Chinese

☐ Italian ☐ Portuguese ☐ Other

☐ Prefer not to answer

Cultural identity (select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care physician provider ID# (HMO ID#, HMO/POS/DPOS only)‡	Primary care office/PCP name (HMO/POS/DPOS only)‡
Provider NPI number	Primary care office address
Current patient of PCP? (HMO/POS/DPOS only)‡ ☐ Yes ☐ No	Primary dental office ID#

‡A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Visit ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a PDO from the Plan's dental HMO network. The member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.
You can also call 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS plans only).

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SECTION 4 — Family information (continued)

Dependent[¶] name: (last, first, middle initial)	Social Security number

Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship code:[§]
_____	____/____/____	_____	☐ M ☐ F ☐ Other ☐ Prefer not to answer	_____

Racial identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural identity (select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

[¶]Children younger than 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

[§]Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
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09 = Adopted child
10 = Foster child
17 = Stepchild
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29 = Domestic partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)

Primary care physician provider ID# (HMO ID#, HMO/POS/DPOS only)‡	Primary care office/PCP name (HMO/POS/DPOS only)‡
Provider NPI number	Primary care office address
Current patient of PCP? (HMO/POS/DPOS only)‡ ☐ Yes ☐ No	Primary dental office ID#

Dependent¶ name: (last, first, middle initial)				Social Security number
Relationship (e.g., son, stepdaughter) _____	Birth date (mm/dd/yy) ___/___/___	Age ____	Sex assigned at birth: ☐ M ☐ F ☐ Other ☐ Prefer not to answer	Relationship code:§ _____

Racial identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

‡A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Visit ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a PDO from the Plan's dental HMO network. The member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.
You can also call 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS plans only).

¶Children younger than 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

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02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic partner
31 = Court appointed guardian

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SECTION 4 — Family information (continued)

Cultural identity (select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care physician provider ID# (HMO ID#, HMO/POS/DPOS only)‡	Primary care office/PCP name (HMO/POS/DPOS only)‡
Provider NPI number	Primary care office address
Current patient of PCP? (HMO/POS/DPOS only)‡ ☐ Yes ☐ No	Primary dental office ID#

SECTION 5 — Dependent information

If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? ☐ Yes ☐ No Is any dependent's last name different from yours? ☐ Yes ☐ No	If you answered yes to either question, please explain.

SECTION 6 — Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance company name	Policy number	
Policy holder	Type of benefits	Effective date / /

‡A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Visit ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a PPDO from the Plan's dental HMO network. The member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.
You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS plans only).

SECTION 6 — Other insurance (continued)

Are you or any of your dependents receiving Medicare benefits? ☐ Yes ☐ No

	Name	Medicare number	Part A effective date	Part B effective date	Reason
Self			/ /	/ /	Check all that apply ☐ Age ☐ Disability ☐ ESRD
Spouse/Domestic partner			/ /	/ /	
Child			/ /	/ /	
Child			/ /	/ /	

SECTION 7 — Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group Name	CID	Payroll/ Work location

Employer or Group Administrator signature	Date	Account number / sub-account number	
	/ /		

Declarations and Conditions of Enrollment

Your application cannot be processed without your signature.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For EPO and PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, Independence Assurance Company, and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross.

PPO Plans are underwritten by Independence Assurance Company.

For HMO/POS and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan East ("Keystone") is governed by the applicable master group contract, which provides that: 1) Except for emergencies and select DPOS services, all medical or dental care must be initiated at the primary care office or primary dental office we have selected; and, 2) I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administrating certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

HMO/POS and DPOS Plans are underwritten by Keystone Health Plan East and QCC Insurance Company.

X _____ / / _____

Employee signature — Date (mm/dd/yy)

_____ _____

Email address — Subscriber's county of residence

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

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Independence

24394 (1/27)

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 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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