Application for Standalone Vision Coverage

Vision Coverage is underwritten by QCC Insurance Company

Instructions:

1. This Application should be used if you wish to enroll in a standalone Vision plan purchased directly from Independence Blue Cross. The health plans available through this Application are not eligible for federal premium tax credits or cost sharing reductions available under the health care law.
2. Please complete all sections and print clearly in black ink.
3. Read carefully and sign the enclosed ***Declarations and Conditions of Enrollment***.
4. Provide information about your spouse, domestic partner, and dependents, if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date. (Sections C and G)
5. Select one of the following payment options for your vision plan.

   First payment:

   - Credit/debit and prepaid debit cards are accepted for the first month's premium. You can:
   - Pay by phone by calling 1-888-879-4891 (TTY: 711)
   - Or, visit ibx.com/payment for instructions on how to pay online through e-Bill

   If you would rather make your first payment by check, mail it along with this application to the address on the form.

   Ongoing payments:

   For instructions on how to set up ongoing payments, visit ibx.com/payment or call 1-866-346-2081 (TTY: 711).

   Important: Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.
6. There is a 30-day Waiting Period applicable to all Covered Services and Supplies.
7. Once your policy is active, if you elect to not renew, you will not be permitted to apply for a new Vision policy with the Company for one year from your renewal date.
8. Once your materials are complete, be sure to make a copy for your records. Mail your application to:

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

All future premium payments should be remitted to the address on your monthly invoice.

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 Independence Blue Cross at 1-844-762-2140, Monday through Friday, between 8 a.m. and 6 p.m. You can also apply online by visiting us at ibx.com/enrollvision.

Independence

For office use only

Application ID: _____

Account ID: _____

Application for Vision Care Coverage

Vision Coverage is underwritten by QCC Insurance Company*

In order to be eligible for coverage, the following must be true:

- The primary applicant must be 19 or older.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Dependent children must be between 19 - 26 years old for Adult plans.

Dependent children up to 26 years old are eligible for the Family Plans.

SECTION A — Plan selections

Choice of Plan			
Standalone Vision Care			
☐ Adult Vision Care 150	☐ Family Vision Care 150	☐ Adult Vision Care 200	☐ Family Vision Care 200

Type of coverage	Reason for application	Method of payment	For office use only
☐ Individual only ☐ Individual and spouse or domestic partner ☐ Parent and child ☐ Parent and child(ren) ☐ Family (parents & children)	☐ New enrollment ☐ Add spouse/domestic partner ☐ Add dependent child(ren) ☐ Renewal (plan change)	☐ Check enclosed ☐ Check Card / Debit Card / Pre-Paid Debit Card (first payment only) – call 1-888-879-4891 or visit ibx.com/payment	Effective date: _____

SECTION B — Primary applicant information (must be 19 or older)

Primary applicant name: Last, first, middle initial			
Social Security Number (required) _____	Birth date (mm/dd/yy) ___/___/___	Age ____	Sex assigned at birth: ☐ 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

*Available to eligible individuals only (see section G: Declarations and Conditions of Enrollment).

†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.

SECTION B — Primary applicant 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				

SECTION C — Family information (if applying)*

Spouse/Domestic Partner name: Last, first, middle initial

Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	____/____/____	_____	☐ 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

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

SECTION C — 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				

Dependent name: Last, first, middle initial

Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	____/____/____	_____	☐ 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		

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

SECTION C — 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				

Dependent name: Last, first, middle initial

Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	____/____/____	_____	☐ 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		

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

SECTION C — 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				

Dependent name: Last, first, middle initial

Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	____/____/____	_____	☐ 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		

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

SECTION C — 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				

SECTION D — Personal information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact information

Home phone number	Mobile phone number	Email address
( )	( )	
Best time to call: ☐ Morning ☐ Afternoon	Best location to call: ☐ Home ☐ Business ☐ Mobile	

SECTION F — Household information

A. Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason:	Address:

B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia? ☐ Yes ☐ No

If no, provide reason:	Address:

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

SECTION D — Declarations and conditions of enrollment

Please read carefully before signing below.

By applying to QCC Insurance Company ("the company") for coverage for myself and the dependents listed in Section C, I understand and agree to the following:

1. a) For your effective coverage date, please see the information in the Premium Rate Letter.
   b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.
   c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month's premium payment only.
   d) Receipt of the initial payment does not constitute enrollment under any program.
   e) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the company. The company reserves the right to investigate and confirm your residence.
2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
4. **By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.**
5. 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.
6. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

Signature(s) Required

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.

SIGN HERE X _____ Applicant/Parent or legal guardian signature _____ / / Date

SIGN HERE X _____ Applicant/Spouse or domestic partner signature (if applying for coverage) _____ / / Date

SECTION E — Statement of accountability (if applicable)

To be completed if the applicant cannot complete or has not completed the application:

I, _____ , have read and completed the application form for the primary applicant for the following reason(s):

☐ Applicant does not speak English ☐ Applicant does not read English

☐ Applicant does not write in English ☐ Other (please explain)

I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by:

_____ _____

Name Signature of translator (required)

____/____/____ _____

Date (required) Relationship to applicant

SECTION F — Broker information (if applicable)

Agent National Producer Number (NPN)	
Primary broker code	Producer broker code
Primary broker name	Producer name
Telephone number	Telephone number

Independence Sales Representative (if applicable)

National Producer Number (NPN)	Name of sales representative

The Adult and Family Vision Plans are underwritten by QCC Insurance Company.

SECTION G — Assistance with completing this application (if applicable)

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Independence Blue Cross. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (first, middle, last)		
Address		Apartment or Suite number
City	State	ZIP code
Phone number		
Organization name (if applicable)		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with Independence Blue Cross.

X _____ ____/____/____

Your signature Date (mm/dd/yy)

Mail your application to:

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

All future premium payments should be remitted to the address on your current invoice.

If you have any questions, contact Independence Blue Cross at 1-844-762-2140 between 8 a.m. and 6 p.m.

Independence

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

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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