The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 215-537-0900. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.iwdcpa.com or call 1-215-537-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network providers $1,500 person / $3,000 family; For Out-of-Network providers $2,750 person / $5,500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary care services, Specialist services and Emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network Medical $6,075 person / $12,075 family; Prescription drug coverage: $1,825 person/$3,725 family; For Out-of-Network providers $8,000 person / $16,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance.	40% coinsurance.	Additional copayments may apply when you receive other services at your provider's office.
	Specialist visit	15% coinsurance.	40% coinsurance.	Chiropractic care 20/visits per year.
	Preventive care/screening/immunization	No charge. Deductible does not apply.	40% coinsurance.	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if performed by HCSC provider, $100 copay/test all other in-network providers.	40% coinsurance.	Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Imaging (CT/PET scans, MRIs)	No charge if performed by HCSC provider, $100 copay/test all other in-network providers.	40% coinsurance.	Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
If you need drugs to treat your illness or condition	Generic Drugs	Retail (30-day supply or 90-day supply of maintenance drugs at retail outlet): 15% coinsurance Mail Order (90-day supply):15% coinsurance	Retail only (30-day supply): 15% coinsurance plus difference between out-of-network cost and allowed amount.	Medical deductible does not apply to prescription drug coverage; separate $100 individual prescription drug deductible applies. No charge for ACA-required generic preventive ugs (such as contraceptives) or (brand drug if eneric is not medically appropriate). a brand name drug is purchased when a generic is available and medically appropriate, you pay the difference in cost, plus applicable copay. Step Therapy is mandatory for all drugs.
	Preferred Brand	Retail (30-day supply): 15% coinsurance. Mail Order (90-day supply): 15% coinsurance.	Retail only (30-day supply): 15% coinsurance plus difference between out-of-network cost and allowed amount.	
	Non Preferred Drugs	Retail (30-day supply): 15% coinsurance. Mail Order (90-day supply): 15% coinsurance.	Retail only (30-day supply): 15% coinsurance plus difference between out-of-network cost and allowed amount.	
	Specialty Drugs	Mail order only: 15% coinsurance.	Not covered.	Preauthorization required. $250/max copay per prescription. Step Therapy mandatory for all drugs. Must use mail order pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance.	40% coinsurance.	Precertification required. *See section General Information. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Physician/surgeon fees	15% coinsurance.	40% coinsurance.	
If you need immediate medical attention	Emergency room care	$150 copay/Visit.	$150 copay/Visit	Copay waived if admitted to hospital.
	Emergency medical transportation	No charge.	No charge.	Preauthorization required for non-emergency use of ambulance. Failure to obtain preauthorization will result in a 20% reduction in benefits.
	Urgent care	$50/Visit.	40% coinsurance.	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)	$500/Day. Max of 10 Copayment(s)/Admission.	40% coinsurance.	Transplants not covered. Failure to obtain preauthorization for non-emergency out-of-network admission will result in $1,000 penalty. Out-of-network inpatient services limited to 70 days/year.
	Physician/surgeon fees	15% coinsurance.	40% coinsurance.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance.	40% coinsurance.	Coverage is through Allied Trades Assistance Program; A.T.A.P.
	Inpatient services	$500/Day. Max of 10 Copayment(s)/Admission.	40% coinsurance.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	15% coinsurance for first visit, no charge thereafter.	40% coinsurance.	Copay only applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-natal care (other than ACA-required preventive screenings) is not covered for dependent children. Failure to obtain preauthorization for birthing center stays that exceed 48 hours (for normal elivery) or 96 hours (for C-section) will result in l,000 penalty. Delivery charges are not covered for dependent children.
	Childbirth/delivery professional services	15% coinsurance.	40% coinsurance.	
	Childbirth/delivery facility services	15% coinsurance.	40% coinsurance.	
If you need help recovering or have other special health needs	Home health care	No charge.	40% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Rehabilitation services	15% coinsurance.	40% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize services provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments.
	Habilitation services	Not covered.	Not covered.	Precertification required. 20% reduction in benefits for failure to pre-authorize services provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments.
	Skilled nursing care	No charge.	40% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment for out-of-network care.
	Durable medical equipment	No charge.	40% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Hospice services	No charge..	40% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge.	Amounts over $20	None. Optical benefits administered separately by National Vision Administrators, LLC (NVA). Medical plan deductible and out-of-pocket limit do not apply to these services.
	Children's glasses	Amounts over $60/frames and no chargers for lenses.	Amounts over $100/frames and $40/single vision lenses or $60 bifocal lenses.	One pair every 2 years or 1 every year if prescription changes. Optical benefits administered separately from medical plan. Medical plan deductible and out-of-pocket limit do not apply to these services.
	Children's dental check-up	Amounts over plan allowance.	Amounts over plan allowance.	Dental benefits administered by Fidelio Dental Insurance Company. Medical plan deductible and out-of-pocket limit do not apply to these services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Accupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Habilitation services
- Long-term care
- Routine foot care
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (20 visits per calendar year)
- Dental care (Adult) (benefit paid up to Plan allowance/preauthorization required for charges of $250 or more).
- Hearing aids (Up to $750 PC Plan allowance every 2 years)
- Infertility treatment (limited to drugs purchased through Fund Office & physician fees)
- Private-duty nursing (outpatient only)
- Routine eye care (Adult) up to $20/exam every 2 years)
- Weight loss programs (as required by the health reform law) (nutrition counseling for weight management only, 6 visits/year).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY: 711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State Insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Pennsylvania Health Insurance Marketplace, visit www.Pennie.gov or call 1-844-844-8040.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Fund Office at Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan, 1807 Spring Garden Street, Philadelphia, PA 19130 or via phone at 1-215-537-0900. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **15%**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,560
Copayments	$360
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,220**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **15%**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,2400
Copayments	$0
Coinsurance	$620
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **15%**
- **Hospital (facility) copayment** **$500**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,510
Copayments	$110
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,730**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pockets expenses.

Glossary of Health Coverage a

- This glossary defines many commonly used terms, but isn't a full lis intended to be educational and may be different from the terms and policy. Some of these terms also might not have exactly the same m any case, the policy or plan governs. (See your Summary of Benefits copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance an life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

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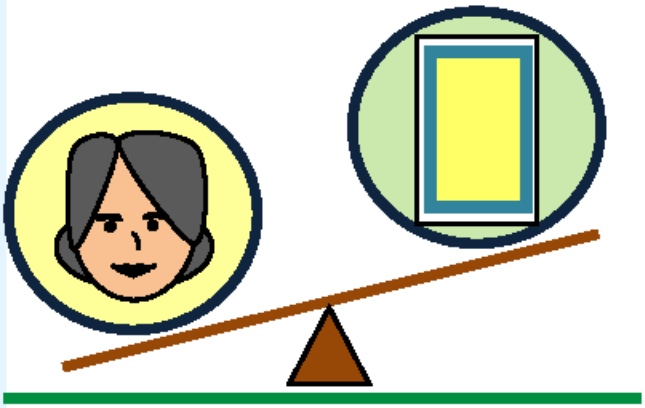
Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (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.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

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

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your

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In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

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 copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-

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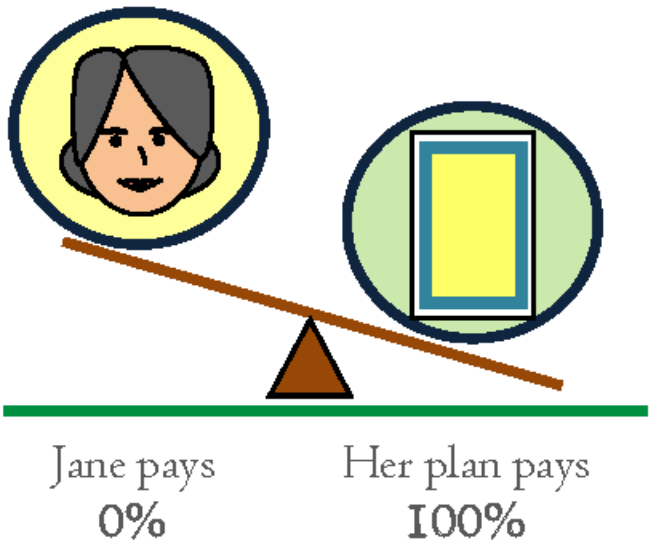

(See page 6 for a detailed example.)

The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health

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Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

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.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

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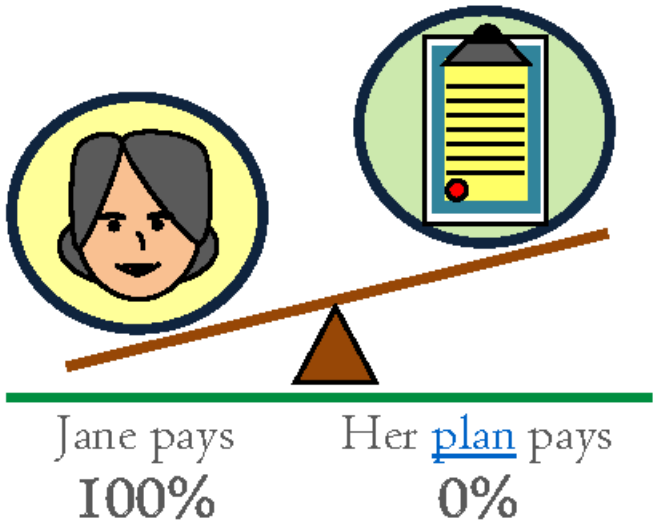
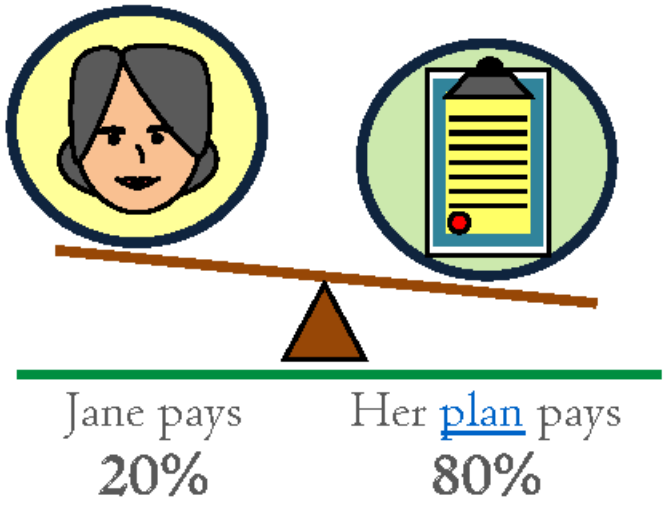
How You and Your Insurer Share Costs - Exam

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Poc**

January 1st
Beginning of Coverage Period



more costs



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

Jane reaches her $1,500 deductible, coinsurance **begins**

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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 differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these 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. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.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*.