

Application for Individual Coverage

Instructions:

1. This Application should be used if you wish to enroll in an Individual health plan purchased directly from Independence Blue Cross (IBX). The health plans available through this Application are not eligible for federal premium tax credits or cost-sharing reductions available under the Affordable Care Act. If you are not sure if you qualify for federal premium tax credits or cost-sharing reductions programs, call 1-866-346-2081 (TTY: 711) for further assistance. Keystone Health Plan East HMO plans are underwritten by Keystone Health Plan East. PPO and EPO health plans are underwritten by QCC Insurance Company.
2. Carefully review and complete each section by printing clearly in black ink.
3. Read carefully and sign the enclosed ***Declarations and Conditions of Enrollment***. Individuals younger than 18 will require a Parent or Legal Guardian signature.
4. Provide information about your spouse, domestic partner, and/or 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. Choose a payment option in Section J. Payment options include:
 - a. **Monthly billing.** You must include a check for the first month's premium.
 - For HMO plans, make your check payable to Keystone Health Plan East.
 - For PPO/EPO plans, make your check payable to Independence Blue Cross.
 - b. **Credit card/debit card or pre-paid debit card.** Complete the credit/debit card portion in Section J. We accept credit cards and most major pre-paid debit cards for all payment (initial and ongoing).

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. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section H) on page 10.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application and check or payment form to:

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

IMPORTANT: Please send future premium payments to the address on your invoice, which will be generated after your application has been processed. If your future premium payments are sent to the P.O. Box noted above, to an incorrect address, or without the coupon enclosed, it could result in a delay with applying your payment and may result in disruption of benefits and/or termination.

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 1-866-346-2081 (TTY: 711), Monday through Friday, between 8 a.m. and 6 p.m. You can also apply online at ibx.com/applynow.



25425



For office use only

Application ID: _____

Account ID: _____

Application/Change form for Individual Coverage

Keystone Health Plan East HMO Plans and QCC Insurance Company PPO/EPO Plans

HMO Plans are underwritten by Keystone Health Plan East. PPO/EPO Plans are underwritten by QCC Insurance Company.

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

- The primary applicant must be between the ages of 0 and 64.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Applicants are not eligible for Medicare or Medicare Disability.
- Dependent children must be younger than 26.

SECTION A – Plan selections

Type of coverage	Reason for application	For office use only
Individual only Individual and spouse or domestic partner Individual and child(ren) Family	New enrollment Change benefit plan Special enrollment Reason: _____	Effective date _____

Choice of plan			
Keystone HMO Plans underwritten by Keystone Health Plan East		Personal Choice PPO/EPO Plans underwritten by QCC Insurance Company	
HMO Gold HMO Silver Essential HMO Bronze	HMO Gold Proactive HMO Gold Proactive Value HMO Silver Proactive Select HMO Silver Proactive Value HMO Bronze Proactive	PPO Gold PPO Gold Preferred PPO Silver Basic PPO Bronze	EPO Bronze Reserve EPO Bronze Basic EPO Bronze Classic EPO Catastrophic*

SECTION B – Primary applicant information (must be between the ages of 0 and 64)

Primary applicant 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
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		

*Available to eligible individuals only (see Section H Declarations and Conditions of Enrollment).

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

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SECTION B — Primary applicant 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 (PCP) ID# (HMO only)‡			Primary care office name (HMO only)‡		Current patient? (HMO only)‡ Yes No
Provider NPI number			Primary Care office address		

SECTION C — 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					
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			

‡Required for all HMO plans. To find a primary care physician (PCP), visit ibx.com/providerfinder or call 1-844-BLUE-4ME (1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

§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)^s

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	Micronesia	German	Dominican (Dominican Republic)
Navajo	Filipino	Jamaican	Native Hawaiian	Irish	Guatemalan
Powhatan Renapec 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 (PCP) ID# (HMO only) [‡]			Primary care office name (HMO only) [‡]		Current patient? (HMO only) [‡] Yes No
Provider NPI number			Primary care office address		
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
_____			____/____/____	_____	
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			

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

[‡]Required for all HMO plans. To find a primary care physician (PCP), visit ibx.com/providerfinder or call 1-844-BLUE-4ME (1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

SECTION C — 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 (PCP) ID# (HMO only) [‡]			Primary care office name (HMO only) [‡]		Current patient? (HMO only) [‡] Yes No
Provider NPI number			Primary care office address		
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
_____			____/____/____	_____	
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			

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

[‡]Required for all HMO plans. To find a primary care physician (PCP), visit ibx.com/providerfinder or call 1-844-BLUE-4ME (1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

SECTION C — Family information (continued)^s

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
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Other	Prefer not to answer				
Primary care physician (PCP) ID# (HMO only) [‡]			Primary care office name (HMO only) [‡]		Current patient? (HMO only) [‡] Yes No
Provider NPI number			Primary care office address		

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	
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			

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

[‡]Required for all HMO plans. To find a primary care physician (PCP), visit ibx.com/providerfinder or call 1-844-BLUE-4ME (1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

SECTION C — 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 Renapec 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 (PCP) ID# (HMO only) [‡]			Primary care office name (HMO only) [‡]		Current patient? (HMO only) [‡] Yes No
Provider NPI number			Primary care office address		

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

[‡]Required for all HMO plans. To find a primary care physician (PCP), visit ibx.com/providerfinder or call 1-844-BLUE-4ME (1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

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

SECTION F — Other insurance

A. Are you or any of your dependents seeking coverage enrolled in Medicare Part A and/or B? Note: If you answered "Yes" to the question above, you and/or your dependents are not eligible for this coverage.	Yes	No
B. Do you currently have any health insurance?	Yes	No
C. Are you replacing the health insurance plan listed in B above? If "Yes," end date of coverage (mm/dd/yy) ___/___/___	Yes	No

Important: Do not cancel any existing coverage until you have received notification that your application has been processed.

If you answered "Yes" to question B or C, provide the following information for each applicant.

Name	Health insurance carrier	Policy number	End date

[¶]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.

SECTION G — Additional information

1. Have you used a tobacco product on average four or more times per week within the past six months, other than for religious or ceremonial use? Yes No

If "Yes": Yes, but I am participating in a tobacco cessation program.
 Yes, and I am not participating in a tobacco cessation program.

The above questions are applicable to members and their dependents ages 21 and older.

Name of person:	Type and amount:	Date last smoked or used tobacco: (mm/dd/yy)
_____	_____	_ / _ / _
_____	_____	_ / _ / _
_____	_____	_ / _ / _
_____	_____	_ / _ / _
_____	_____	_ / _ / _
_____	_____	_ / _ / _

SECTION H — Declarations and Conditions of Enrollment

Please read carefully before signing below.

By applying to Keystone Health Plan East or QCC Insurance Company (“the companies”) for coverage for myself and the dependents listed in Section C, I understand and agree as follows:

1. a) Effective date of coverage will be the 1st day of each month.
 b) Coverage does not begin until this application is processed by the companies with an effective date of coverage assigned and payment has been received.
 c) If paying by check, a check for the first monthly premium must be submitted with your paper application.
 d) Credit card/debit card payments are acceptable for the first month’s premium payment and ongoing payments.
 e) Receipt of the initial payment does not constitute enrollment under any program.
 f) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania, served by the companies. The companies reserve the right to investigate and confirm your residence.
2. The companies 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 companies, and the companies 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. **HMO Plans Only:**
 a) As a condition of coverage, each applicant must select an in-network primary care physician.
 b) As a condition of coverage (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement), all services, in order to be covered by Keystone Health Plan East, must be performed either by an in-network primary care physician, or an in-network specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral or precertification from an in-network primary care physician or Keystone Health Plan East.
5. **Catastrophic Plans Only:**
 Catastrophic Plans are available to eligible applicants (Individual/Family) younger than 30 or eligible applicants experiencing a documented hardship and have received a certification from the Federal Government and/or Commonwealth of Pennsylvania.
6. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
7. 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 companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
8. 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.
9. 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 and 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.

<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; padding: 2px; margin-right: 5px; writing-mode: vertical-rl; transform: rotate(180deg); font-size: 8px;">SIGN HERE</div> <div style="margin-left: 10px;"> <p style="margin: 0;">X _____</p> <p style="margin: 0;">Applicant/Parent or legal guardian signature</p> </div> <div style="margin-left: 20px;"> <p style="margin: 0;">_____/_____/_____ Date</p> </div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; padding: 2px; margin-right: 5px; writing-mode: vertical-rl; transform: rotate(180deg); font-size: 8px;">SIGN HERE</div> <div style="margin-left: 10px;"> <p style="margin: 0;">X _____</p> <p style="margin: 0;">Applicant/Spouse or domestic partner signature (if applying for coverage)</p> </div> <div style="margin-left: 20px;"> <p style="margin: 0;">_____/_____/_____ Date</p> </div> </div>
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SECTION I – 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 J – Payment mode

Check	Check number	_____			
Credit/debit card type	American Express	Discover	Mastercard	Visa	
Credit/debit card number	_____	Expiration date	_____	Security code	_____
Cardholder name	_____				

SECTION K – 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 Blue Cross Sales Representative (if applicable)

National Producer Number (NPN)	Name of sales representative
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SECTION L — 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 name, middle name, last name)		
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 and check or Payment Form to:

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

IMPORTANT: Please send future premium payments to the address on your invoice, which will be generated after your application has been processed. If your future premium payments are sent to the P.O. Box noted above, to an incorrect address, or without the coupon enclosed, it could result in a delay with applying your payment and may result in disruption of benefits and/or termination.

If you have any questions or need help completing this application, contact IBX at 1-866-346-2081 (TTY: 711), Monday through Friday, between 8 a.m. and 6 p.m.



Independence Blue Cross offers products through its subsidiaries Independence Assurance Company, 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 مجاناً لضمان وصول المعلومات إليك بصيغة ميسرة 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 fòm aksèsib 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 કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ्त में उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ्त 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を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。

한국어: 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 yáníłt'i'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahj'i' bee adahodooníłí diné bich'i' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígíí áldó' t'áá jiik'eh hóló. Kohj'i' 1-800-275-2583 (TTY: 711) hodíłlnih doodago níka'análawo'í bich'i' hanidziih.

Pennsilfaanisch-Deutsch: WICH DICH: Wann du Deutsch schwetzsch, kenne mer dich Schprouch-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) నంబర్ కు కాల్ చేయండి లేదా మీ ప్రొవైడర్ తో 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 isẹ àtilẹhin èdè lófẹẹ wà lárọwótó rẹ. Àwọn isẹ àtilẹhin ìrànlowó tó yẹ láti pèsè iwífúnni ni ọna irááyèsi kíkà wà lárọwótó bakanna lófẹẹ. Pe 1-800-275-2583 (TTY: 711) tàbí ki ó bá olùpèsè rẹ sọrọ.

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: civilrightscordinator@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.