Benefit Summary

Plan Name:	iDirect Gold Copay		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$1,700 / $3,400	$7,500 / $15,000	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	50%	
Out-of-Pocket Maximum	$7,000 / $14,000	$15,000 / $30,000	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
Annual Maximum	Not Applicable	Not Applicable	
Lifetime Maximum	Not Applicable	Not Applicable	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy Sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal visits Post-Partum visits Prostate test (Prostate Specific Antigen "PSA") Well-Child visit Well-Woman visit	$0	Deductible then 50% coinsurance	All preventive services are covered in full with $0 member liability when performed by a participating provider. See independenthealth.com for additional information.
Physician and Other Services			
Primary Office Visit	$20 copay / visit	Deductible then 50% coinsurance	No copay for first 3 visits
Specialist Office Visit	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Allergy Testing & Treatment	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures (in physician's office)	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Telemedicine - General Medical Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Behavioral Health Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Dermatology	$0 copay / consultation	Not Covered	Administered by Teladoc

Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Emergency & Urgent Care Services			
Emergency Room	Deductible then $200 copay / visit	Deductible then $200 copay / visit	Copay waived if admitted
Ambulance	Deductible then $150 copay / trip	Deductible then $150 copay / trip	Must be deemed medically necessary
Urgent Care Center	$75 copay / visit	$75 copay / visit	
Hospital and Other Facility Services			
Inpatient Hospital	Deductible then $1,000 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 50% coinsurance	
Inpatient Hospice	Deductible then $0 copay / admission	Deductible then 50% coinsurance	Up to 210 days per plan year
Outpatient Surgical Procedures (Hospital Facility)	Deductible then $375 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	Deductible then $325 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 50% coinsurance	
Skilled Nursing Facility	Deductible then $1,000 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	Deductible then $20 copay / visit	Deductible then 50% coinsurance	
EKG	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine Radiology	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Advanced Radiology	Deductible then $85 copay / visit	Deductible then 50% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$0 copay / visit	Deductible then 50% coinsurance	No charge after the initial diagnosis. Provided in accordance with USPSTF and HRSA guidelines
Inpatient Maternity	Delivery: Deductible then $1,000 copay / admission Physician: Deductible then $0 copay / procedure	Deductible then 50% coinsurance	Semi-private room, per admission

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Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Mental Health & Substance Abuse			
Inpatient Mental Health	Deductible then $1,000 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Outpatient Mental Health	$20 copay / visit	Deductible then 50% coinsurance	No copay for first 3 visits
Inpatient Substance Abuse - Rehab	Deductible then $1,000 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Inpatient Substance Abuse - Detox	Deductible then $1,000 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Outpatient Substance Abuse	$20 copay / visit	Deductible then 50% coinsurance	No copay for first 3 visits
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$0 copay	Deductible then 50% coinsurance	
Insulin and Other Oral Agents	$0 copay	Deductible then 50% coinsurance	Oral Agents at applicable cost share
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 copay	Deductible then 50% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then $50 copay / visit	Deductible then 50% coinsurance	60 visits per condition, per plan year combined therapies
Cardiac Rehabilitation	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Pulmonary Rehabilitation	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Additional Services			
Durable Medical Equipment	Deductible then 50% coinsurance	Deductible then 50% coinsurance	
Prosthetics and Appliances	Deductible then 50% coinsurance	Deductible then 50% coinsurance	
Chemotherapy Visits	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	See Medications Administered in an Office or Outpatient Hospital Setting for additional member liability
Medications Administered in an Office or Outpatient Hospital Setting	10% coinsurance / Deductible then 10% coinsurance	Deductible then 50% coinsurance	Excludes Allergy Injections
Home Health Care	Deductible then $50 copay / visit	Deductible then 50% coinsurance	Up to 40 visits per plan year
RedShirt Rewards	Earn up to $30 in rewards for covered members ages 18 and up per plan year for completing health related actions.	Not Covered	
Unique Benefits	Health Extras: $250 allowance per Plan Year or Nutrition Reimbursement: Up to $500 per individual/$1,000 per family	Not Covered	After your effective date you must choose either Health Extras or Nutrition Reimbursement

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Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Prescription Drug Coverage			
Prescription Plan	$10/$75/50%	Not Covered	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary II. Cost-share, if applicable, does not apply to certain prescription drugs. Visit our website to review our formulary.
Maintenance Medications	2.5 copays for a 3 month supply, Deductible may apply	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
Medicare Part D Creditable Coverage Status	Creditable*	Not Applicable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.
Pediatric Vision Services			
Medical Eye Exam	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine/ Refractive Exam	$20 copay / visit	Not Covered	Once every 12 months
Standard Plastic Lenses	30% coinsurance	Not Covered	Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
Frames	30% coinsurance	Not Covered	Once every 12 months
Conventional Contact Lenses	30% coinsurance	Not Covered	Once every 12 months. In lieu of frames/lenses. Materials only.
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Adult Vision Services			
Medical Eye Exam	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine/ Refractive Exam	$40 copay / visit	Not Covered	Once every 12 months
Standard Plastic Lenses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% off most retail frames	Not Covered	
Conventional Contact Lenses	15% off retail price	Not Covered	Materials only
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Dental Services			
Preventive and Routine	Not Covered	Not Covered	
Accidental Dental	Based on services rendered	Based on services rendered	Must be deemed medically necessary

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Benefit Summary

Plan Name:	iDirect Gold Copay		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month
Important Notes			

Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.

Embedded: On a single policy, the single deductible/out-of-pocket max must be met before Independent Health provides reimbursement for coveredin-network or out-of-network services. On a family policy, once a family member meets the single deductible/out-of-pocket max, the deductible/out-of-pocket max is satisfied for that member. However, additional family members must satisfy the remainder of the family deductible/out-of-pocket maxbefore Independent Health provides reimbursement for covered in-network or out-of-network services.

Non-Embedded (True Family): On a single policy, the single deductible/out-of-pocket max must be met before Independent Health providesreimbursement for covered in-network or out-of-network services. On a family policy, the entire family deductible/out-of-pocket max must be metbefore Independent Health provides reimbursement for covered in-network or out-of-network services. An individual on a family policy will NOT stop atthe single deductible/out-of-pocket max.

Out-of-Network (if applicable): Member is responsible for the difference between Independent Health's allowed amount and the non-participatingprovider's billed amount.

PCP requirement is based on benefit plan type: POS Plan Type = PCP Required or PPO Plan Type = PCP Optional

Member Pre-Authorization: Certain services and benefits are subject to member pre-authorization. Member is responsible for contacting IndependentHealth for pre-authorization.

Child (if applicable): Cost-share applies if member is under the age of 19.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contractand may be subject to change. For more detailed information, consult your Contract, attached Riders (if any), or Certificate of Coverage.

All indicated benefits assume the member has appropriate authorization to receive services.

Certain benefits stated in this benefit summary may be pending NYS approval

Independent Health. iDirect Gold Copay HSAQ

Coverage for: All Tier Levels | **Plan Type: EPO**

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 1-800-501-3439 or visit www.independenthealth.com. 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.independenthealth.com or call 1-800-501-3439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,750 Individual / $3,500 Family Out-of-network: Not covered	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 and other major categories of service, as identified in the SBC, are not subject to 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 network providers $8,500 Individual / $17,000 Family; for out-of-network providers: Unlimited	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-billed charges, penalty amounts, and non-covered services.	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.independenthealth.com or call 1-800-501-3439** 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	$20 copay / visit	Not Covered	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Specialist visit	$50 copay / visit	Not Covered	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Preventive care/screening/immunization	No charge	Not Covered	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. Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $50 copay / visit; Blood work: $20 copay / visit; EKG: $20/$50 copay / visit	Not Covered	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Imaging (CT/PET scans, MRIs)	$85 copay / visit	Not Covered	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com	Preferred Generic Drugs (Tier 1)	$10	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Generic Drugs (Tier 2)	$40	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Brand Name Drugs (Tier 3)	50%	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$375 copay / visit	Not Covered	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Physician/surgeon fees	$0 copay / visit	Not Covered	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you need immediate medical attention	Emergency room care	$200 copay / visit	Not Covered	Copay waived if admitted
	Emergency medical transportation	$150 copay / trip	Not Covered	Must be deemed medically necessary
	Urgent care	$75 copay / visit	Not Covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Physician/surgeon fees	$0 copay / visit	Not Covered	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit	Not Covered	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Inpatient services	$1,000 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you are pregnant	Office visits	$0 copay / visit	Not Covered	No charge after the initial diagnosis. Provided in accordance with USPSTF and HRSA guidelines
	Childbirth/delivery professional services	Physician: $0 copay / procedure	Not Covered	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Childbirth/delivery facility services	Delivery: $1,000 copay / admission	Not Covered	Semi-private room, per admission

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 need help recovering or have other special health needs	Home health care	$50 copay / visit	Not Covered	Up to 40 visits per plan year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Rehabilitation services	$50 copay / visit	Not Covered	60 visits per condition, per plan year combined therapies
	Habilitation services	$50 copay / visit	Not Covered	---None---
	Skilled nursing care	$1,000 copay / admission	Not Covered	Semi-private room, per admission Unlimited days per plan year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Durable medical equipment	50% coinsurance	Not Covered	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Hospice services	$0 copay / admission	Not Covered	Up to 210 days per plan year
If your child needs dental or eye care	Children's eye exam	$20 copay / visit	Not Covered	Once every 12 months
	Children's glasses	30% coinsurance	Not Covered	Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
	Children's dental check-up	Not Covered	Not Covered	---None---

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.)		
• Acupuncture	• Long-Term Care	• Routine Eye Care (Adult)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care
• Dental Care (Adult)	• Private-Duty Nursing	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion Services	• Chiropractic Care	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too,including buying individual insurance through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York at 1-888-614-5400 or http://www.communityhealthadvocates.org/.

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,

Language Access Services:
Please refer to Nondiscrimination statement and language assistance services contained within.
In accordance with Section 1303 of the Patient Protection and Affordable Care Act, at least $1.00 of the total premium amount owed per enrollee per month is a payment for coverage of non-Hyde abortion services.

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	$1750
Specialist coinsurance	$50
Hospital (facility) coinsurance	$1000
Other coinsurance	$50

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	$12700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1700
Copayments	$1900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3660

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

The plan's overall deductible	$1750
Specialist coinsurance	$50
Hospital (facility) coinsurance	$1000
Other coinsurance	$50

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	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1700
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1840

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

The plan's overall deductible	$1750
Specialist coinsurance	$50
Hospital (facility) coinsurance	$1000
Other coinsurance	$50

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	$1900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1700
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1800

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Independent Health Member Services at 1-800-501-3439.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination statement and language assistance services

If you, or someone you're helping, have questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

如果您，或是您正在協助的對象，有關於[插入 Independent Health **項目的名稱**Independent Health **方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入數字**1-800-501-3439。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

만약귀하또는귀하가돕고있는어떤사람이 Independent Health **에관해서질문이있다면귀하는그러한 도움과정보를귀하의언어로비용부담없이얻을수있는권리가 있습니다. 그렇게통역사와얘기하기 위해서는** 1-800-501-3439 **로전화하십시오.**

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

אויב איר, אודר עמצער איר העלפסט. האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך
אומזיסט. צו רעדן מיט דער אי'בערזעצער, קלונג 1-800-501-3439

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health
অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3739

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-501-3439

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

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Independent Health

اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال ہے Independent Health کے بارے میں، تو آپ دونوں کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-800-501-3439 فون کریں۔

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap angisang tagasalin, tumawag sa
1-800-501-3439.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Discrimination is Against the Law

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

Independent Health:

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

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health 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: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department 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**

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