



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 1-833-803-4458 or visit us at [www.amerihealthtpa.com](http://www.amerihealthtpa.com). For 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-833-803-4458 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$1,200 person / \$2,400 family combined In-Network and Out-of-Network. Applies to medical and prescription costs.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. Well child care, prenatal care, and <a href="#">In-Network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other <a href="#">deductibles</a> for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</a>	For <a href="#">In-Network providers</a> \$1,200 person / \$2,400 family, for <a href="#">Out-of-Network providers</a> \$3,500 person / \$6,500 family. Applies to medical and prescription costs.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the <a href="#">out-of-pocket limit</a>?</a>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a <a href="#">network provider</a>?</a>	Yes. See <a href="http://www.amerihealthtpa.com">www.amerihealthtpa.com</a> or call: 1-833-803-4458 for a list of <a href="#">In-Network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</a>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---None---
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---None---
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> waived	Well child: No charge Adult: 20% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---None---
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification may be required for some imaging services.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.smithrx.com">www.smithrx.com</a>	Generic drugs	0% <a href="#">coinsurance</a> retail 0% <a href="#">coinsurance</a> mail order 0% <a href="#">coinsurance</a> 90dayRx retail	0% <a href="#">coinsurance</a> retail Mail order and 90dayRx retail: Not Covered	Covers up to a 31-day supply retail; 90-day supply mail order and 90dayRx retail. No coverage for mail order and 90dayRx retail services from <a href="#">Out-of-Network providers</a> . No coverage for non-preferred drugs. Insulin listed on the preferred generic/preferred brand <a href="#">prescription drug</a> list are covered at zero <a href="#">cost-sharing</a> . The value of drug coupons you use will not count towards <a href="#">cost-sharing</a> or <a href="#">out-of-pocket limits</a> . May require prior authorization.
	Preferred brand drugs	0% <a href="#">coinsurance</a> retail 0% <a href="#">coinsurance</a> mail order 0% <a href="#">coinsurance</a> 90dayRx retail	0% <a href="#">coinsurance</a> retail Mail order and 90dayRx retail: Not Covered	
	Non-preferred drugs	Not Covered	Not Covered	---None---
	<a href="#">Specialty drugs</a>	Refer to applicable <a href="#">prescription drug cost sharing</a>	Not Covered	Covers up to a 31-day supply at participating <a href="#">specialty drug network</a> supplier. May require prior authorization.
	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification may be required for some outpatient surgeries.
If you have outpatient surgery	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Out-of-Network services apply to the <a href="#">In-Network deductible</a> and <a href="#">out-of-pocket limit</a> .
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Out-of-Network services apply to the <a href="#">In-Network deductible</a> and <a href="#">out-of-pocket limit</a> .

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)	
	<u><a href="#">Urgent care</a></u>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification is required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification may be required for certain specialty services.
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification is required.
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: 0% <a href="#">coinsurance</a>	Prenatal care: No charge Postnatal care: 20% <a href="#">coinsurance</a>	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost-sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Precertification is required for inpatient delivery services.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<u><a href="#">Home health care</a></u>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification is required.
	<u><a href="#">Rehabilitation services</a></u>	0% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	20% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	Precertification may be required.
	<u><a href="#">Habilitation services</a></u>	0% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	20% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	
	<u><a href="#">Skilled nursing care</a></u>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification is required. Limited to 120 days per person per benefit period.
	<u><a href="#">Durable medical equipment</a></u>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification is required for some items.
	<u><a href="#">Hospice services</a></u>	0% <a href="#">coinsurance</a>	Not Covered	Precertification is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Age 0 through 5: No charge Age 6 through 18: 20% <a href="#">coinsurance</a>	---None---
	Children's glasses	Not Covered	Not Covered	---None---
	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.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li></ul>
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**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), visit [www.HealthCare.gov](http://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: 1-833-803-4458 or [www.amerihealthtpa.com](http://www.amerihealthtpa.com). 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](http://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 the 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](http://Marketplace.gov).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-352-1706.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-352-1706.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-352-1706.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo holne' 1-844-352-1706.

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,200
■ <a href="#">Specialist coinsurance</a>	0%
■ <a href="#">Hospital (facility) coinsurance</a>	0%
■ <a href="#">Other coinsurance</a>	0%

**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:**

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions **\$60**

**The total Peg would pay is** **\$1,260**

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,200
■ <a href="#">Specialist coinsurance</a>	0%
■ <a href="#">Hospital (facility) coinsurance</a>	0%
■ <a href="#">Other coinsurance</a>	0%

**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:**

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions **\$20**

**The total Joe would pay is** **\$1,220**

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,200
■ <a href="#">Specialist coinsurance</a>	0%
■ <a href="#">Hospital (facility) coinsurance</a>	0%
■ <a href="#">Other coinsurance</a>	0%

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

**Total Example Cost** **\$2,800**

**In this example, Mia would pay:**

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions **\$0**

**The total Mia would pay is** **\$1,200**

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# 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 1-844-352-1706 (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 بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 1-844-352-1706 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

**বাংলা:** দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূলে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূলে উপলব্ধ। 1-844-352-1706 (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 1-844-352-1706 (TTY: 711) 或咨询服务提供者。

**فارسی:** توجه: اگر به فارسی صحبت می‌کنید، خدمات رایگان زبان در دسترس شما است. کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان موجود است. با شماره 1-844-352-1706 (TTY: 711) یا 6071-253-448-1 تماس بگیرید یا با ارائه‌کنندگان صحبت کنید.

**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 1-844-352-1706 (TTY: 711) ou parlez-en à votre fournisseur.

**Kreyòl Ayisyen:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-844-352-1706 (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. 1-844-352-1706 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

**Lus Hmoob:** TSEEM CEEB: Yog hais tias koj hais Lus Hmoob, yuav muaj kev pab txhais lus dawb rau koj. Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam tsim nyog los muab cov ntaub ntawv hauv cov qauv siv tau yam tsis tau them nyaj. Hu rau 1-844-352-1706 (TTY: 711) los sis tham nrog koj tus kws muab kev pab cuam.

**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 1-844-352-1706 (TTY: 711) oppure rivolgiti al tuo fornitore.

**日本語:** 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-844-352-1706 (TTY: 711) にお電話くださいか、または、プロバイダーにお問い合わせください。

ကညီကို ပုံသိပ်သံတက္ကာ- နမ်စံးကတို့ [ကညီကို]နှင့်၊  
တုမေစားသုံးဒီးကိုတုကတို့ အတုမေလာ ဘူးလဲကလိနှင့်  
နှိုးနှုံးအီသုံးလို့၊ ပီးလီမေစားပုံက္ကာဂို့တုကျားတဖိုး  
တုတိစာမေစားအတုမေတဖိုးလာအကြေးအသာ်  
လေကဟုံ့တုရှုတ်ကျိုးနှင့် တုံးနှုံးအီသုံးလို့၊  
ကုံးလေစားတုံးနှုံးအီသုံးလို့ လေအားအလဲကလို့ကိုနှုံးလို့၊ ကို  
1-844-352-1706 (TTY: 711) မူတမ်း ကတို့တုံး  
နှုံးမေစားတုရှုတ်က္ကား。

**한국어를:** 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-844-352-1706 (TTY: 711)에 전화하시거나 서비스 제공업체에 문의하세요.

**Diné bizaad:** BAA'ÁKONÍNÍZIN: Diné bizaad bee yánífti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjí' bee adahodooníti diné bich'í' anídahazt'í'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaígíí ałdó' t'áá jiik'eh hóló. Kohjí' 1-844-352-1706 (TTY: 711) hodíilnih doodago níka'análawo'í bich'í' hanidziih.

**Anishinaabemoyan:** WAABANDAN O'OW: Giishpin Anishinaabemoyan, gidaa-wiidookaagoo wenipazh jinisidotaagoziyan giishpin nandawendaman. Anooj gegoon dash gidaa-wiidookaagoo jinisidawendaagoziyan wenipazh gaye. Aabajitoon o'ow asigibii'igan 1-844-352-1706 (TTY: 711) gemaa dash gaganoozh mino-ayaawin waadookaaged.

**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 1-844-352-1706 (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 1-844-352-1706 (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 1-844-352-1706 (TTY: 711) или обратитесь к своему провайдеру.

**Soomali:** FIIRO GAAR AH: Haddii aad ku hadashid Soomaali, adeegyada caawinta luuqada ayaa laguu heli karaa. Caawinada maqalka ku haboon iyo adeegyo lagu bixinayo warbixinta qaababka lagu heli karo ayaa sidoo kale lagu heli karaa si bilaash ah. Ka soo wac 1-844-352-1706 (TTY:711) ama la hadal bixiyahaaga.

**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 1-844-352-1706 (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 na-access na format nang walang bayad. Tumawag sa 1-844-352-1706 (TTY:711) o makipag-usap sa iyong provider.

**Tiếng Việt:** LUU 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 1-844-352-1706 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

## Discrimination Is Against the Law

AmeriHealth Administrators 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.

AmeriHealth Administrators:

- 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 AmeriHealth Administrators 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:

ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA, 19103, by phone: 1-844-352-1706 (TTY: 711), by fax: 215-761-0920, or by email: [AHCivilRightsCoordinator@ahatpa.com](mailto:AHACivilRightsCoordinator@ahatpa.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: [amerihealthtpa.com](http://amerihealthtpa.com).