



2027

Summary

of Benefits

**Medicare Advantage Plans with Part D
Prescription Drug Coverage**

AmeriHealth Medicare Core PPO

January 1, 2027 – December 31, 2027

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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage*. You can also see the *Evidence of Coverage* on our website, amerihealthmedicare.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare Advantage health plan (such as AmeriHealth Medicare Core PPO).

Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what AmeriHealth Medicare Core PPO covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits* booklets. Or, use the Medicare Plan Finder on medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About AmeriHealth Medicare Core PPO
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits (Part D).
- Other Medical Benefits.

This document is available in other formats such as Braille and large print.

To receive this document in an alternate format such as Braille, large print, or audio, please call **1-800-898-3492** (TTY/TDD: **711**) (non-members) (by calling this number you will be directed to a licensed sales agent) or **1-866-569-5190** (TTY/TDD: **711**) (members).

Things to Know About AmeriHealth Medicare Core PPO

Hours of Operation & Contact Information

- If you are a member of this plan, call our Member Help Team at **1-866-569-5190** (TTY/TDD: **711**), seven days a week, 8 a.m. to 8 p.m.
- If you are not a member of this plan, call **1-800-898-3492** (TTY/TDD: **711**), seven days a week, 8 a.m. to 8 p.m. By calling this number you will be directed to a licensed sales agent.
- Please note that on weekends and holidays from January 1 through September 30, your call may be sent to voicemail.
- Our website: amerihealthmedicare.com.

Who can join?

To join AmeriHealth Medicare Core PPO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area includes the following counties in New Jersey: Camden.

Which doctors, hospitals, and pharmacies can I use?

AmeriHealth Medicare Core PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, a higher cost-sharing may apply.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider/Pharmacy Directory* on our website at amerihealthmedicare.com.

Or, call us and we will send you a copy of the *Provider/Pharmacy Directory*.

What do we cover?

We cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

AmeriHealth Medicare Core PPO covers Part D prescription drugs. In addition, the plan covers Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan *Formulary (List of Covered Drugs)* and any restrictions on our website at [amerihealthmedicare.com](https://www.amerihealthmedicare.com).
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, and Catastrophic Coverage.

If you have any questions about the plan's benefits or costs, please contact AmeriHealth

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SECTION II - SUMMARY OF BENEFITS

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	AmeriHealth Medicare Core PPO
Monthly Plan Premium	\$18 per month.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$700 for Tiers 3, 4 and 5.
Maximum Out-of-Pocket (MOOP) Amount (the amounts you pay for your premium, Part D prescription drugs, and some medical services do not count toward the annual MOOP amount)	Your yearly limit in this plan: • \$9,850 for services you receive from in-network providers. • \$14,800 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.

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SECTION III - SUMMARY OF BENEFITS

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Inpatient Hospital Coverage (1)	<u>In-Network:</u> \$420 copay per day for days 1-5 per admission. \$0 copay per day for days 6 and beyond per admission. \$0 copay on day of discharge; unlimited days per benefit period. \$2,100 maximum copay per admission. <u>Out-of-Network:</u> 50% of the total cost per stay.
Outpatient Hospital Coverage (1)	<u>In-Network:</u> Outpatient hospital observation: \$420 copay per stay. Outpatient hospital services: \$595 copay. <u>Out-of-Network:</u> 50% of the total cost.
Ambulatory Surgical Center (ASC) Services (1)	<u>In-Network:</u> \$525 copay. <u>Out-of-Network:</u> 50% of the total cost.
Doctor Visits (Primary Care Providers and Specialists)	<u>In-Network:</u> Primary care physician: \$0 copay per visit. Specialist: \$55 copay per visit. <u>Out-of-Network:</u> 50% of the total cost.
Preventive Care (1)	<u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare at zero cost sharing.

Services with a (1) may require prior authorization (in-network only).

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Preventive Care (1) (continued)	Please refer to the <i>Evidence of Coverage</i> for a complete listing of services. If you receive a separate additional non-preventive evaluation and/or service, a copay will apply. The copay amount depends on the provider type or place of service. <u>Out-of-Network:</u> 50% of the total cost for all preventive services covered under Original Medicare at zero cost sharing.
Emergency Care Worldwide copay outside of the United States does not count toward the annual MOOP amount	<u>In-Network and Out-of-Network:</u> Emergency care: \$115 copay per visit. Worldwide emergency coverage: \$115 copay per visit. Not waived if admitted.
Urgently Needed Services Worldwide copay outside of the United States does not count toward the annual MOOP amount	<u>In-Network and Out-of-Network:</u> Retail clinic: \$10 copay per visit. Urgent care center: \$40 copay per visit. Worldwide urgent coverage: \$115 copay per visit. Not waived if admitted.
Diagnostic Services, Labs, and Imaging (1)	<u>In-Network:</u> Diagnostic tests and procedures: \$0 copay. Lab services: \$0 copay. Diagnostic radiology services (such as MRI, CAT Scan): \$0 copay - \$500 copay. X-rays: \$40 copay. Therapeutic radiology services (such as radiation therapy): \$80 copay per visit. <u>Out-of-Network:</u> 50% of the total cost. Therapeutic radiology services (such as radiation therapy): 50% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Hearing Services	Medicare-covered Hearing Exams <u>In-Network:</u> \$55 copay. <u>Out-of-Network:</u> 50% of the total cost. Routine Hearing Exams (up to 1 visit every year) <u>In-Network:</u> \$0 copay. <u>Out-of-Network:</u> 95% of the total cost. Routine Hearing Aids <u>In-Network:</u> Advanced digital hearing aid: \$699 copay per aid. Premium digital hearing aid: \$999 copay per aid. Advanced and premium include a rechargeable hearing aid option. Unlimited hearing aid fittings and evaluations for the first year; up to two hearing aids every year, one hearing aid per ear. Routine hearing services and aids are covered when provided by a TruHearing® provider. Routine hearing services do not count toward the annual MOOP amount. <u>Out-of-Network:</u> 95% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Dental Services	Medicare-covered Dental Services <u>In-Network:</u> \$55 copay. <u>Out-of-Network:</u> 50% of the total cost. Routine Dental Care <u>In-Network:</u> \$0 copay for routine non-Medicare-covered exams/cleaning/fluoride services. \$0 copay for one set of dental bitewing X-rays every 12 months, one periapical X-ray every 36 months, and one full-mouth X-ray (panoramic) every 36 months. <u>In-Network and Out-of-Network:</u> Routine dental services do not count toward the annual MOOP amount. <u>Out-of-Network:</u> 80% coinsurance for routine dental exam, cleaning services, and fluoride treatment. 80% coinsurance for dental X-ray. Member must use a participating AH Medicare Dental Network provider for in-network coverage.
Vision Services	Medicare-covered Vision Services <u>In-Network:</u> Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): \$55 copay. Medicare-covered glaucoma screening: \$0 copay. <u>Out-of-Network:</u> Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): 50% of the total cost. Medicare-covered glaucoma screening: 50% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Vision Services (continued)	Routine Vision Care <u>In-Network:</u> \$0 copay for one routine eye exam every year. One pair of contact lenses or one pair of eyeglass frames and lenses are covered in full every year if purchased from the Davis Vision Collection. \$200 allowance every year for eyewear (frames and lenses) purchased from Visionworks®. \$100 allowance every year for all other eyewear (frames and lenses) purchased at a network Davis Vision provider. \$100 allowance every year for contact lenses in lieu of routine eyewear (frames and lenses). Eyewear coverage does not include lens options such as tints, progressives, transitions lenses, polish, and insurance. <u>In-Network and Out-of-Network:</u> Routine vision services do not count toward the annual MOOP amount. <u>Out-of-Network:</u> 80% of the total cost. Eyewear (frames and lenses, or contact lenses) have a \$100 combined in-and out-of-network plan maximum benefit payable per year. Visionworks providers are national, so up to \$200 combined maximum applies when in or out of the service area.
Mental Health Services (1)	<u>In-Network:</u> Outpatient mental health care: • Group therapy visit: \$20 copay. • Individual therapy visit: \$40 copay. Inpatient mental health care: • \$410 copay per day for days 1-5 per admission. • \$0 copay per day for days 6 and beyond per admission.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Mental Health Services (1) (continued)	• \$0 copay on day of discharge. • \$2,050 maximum copay per admission. • 190-day lifetime maximum. Outpatient substance abuse services: • Group therapy visit: \$20 copay. • Individual therapy visit: \$40 copay. Partial hospitalization and intensive outpatient services: • \$55 copay per day. <u>Out-of-Network:</u> 50% of the total cost.
Skilled Nursing Facility (SNF) (1)	<u>In-Network:</u> Days 1-20: \$0 copay per day. Days 21-100: \$221 copay per day. 100 days per benefit period. <u>Out-of-Network:</u> 30% of the total cost per stay.
Outpatient Rehabilitation Services (Physical therapy, occupational therapy, and speech therapy)	<u>In-Network:</u> Occupational therapy: \$35 copay per visit. Physical and speech therapy: \$55 copay per visit <u>Out-of-Network</u> 50% of the total cost.
Ambulance (1) (Ground and air transportation)	<u>In-Network:</u> \$335 copay per one-way trip. Not waived if admitted. In-Network non-emergency ambulance services require prior authorization.

COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Ambulance (1) (continued) (Ground and air transportation)	<u>Out-of-Network:</u> \$335 copay per one-way trip.
Transportation	Not covered.
Medicare Part B Drugs (1) (Step therapy required for certain Part B drugs)	<u>In-Network:</u> For Part B drugs, including chemotherapy drugs: 0% - 20% of the total cost. You pay no more than \$35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump. <u>Out-of-Network:</u> 50% of the total cost.

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SECTION IV - SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS (PART D)

Deductible

Prescription Drug Deductible: \$700 for Tiers 3, 4 and 5.

Initial Coverage

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move on to the Catastrophic Coverage Stage.

Preferred Retail Cost-sharing

	AmeriHealth Medicare Core PPO
Tier	One-month supply
1 (Preferred Generic)	\$0 copay
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	25% coinsurance
Insulin (Tiers 3, 4, and 5)	\$35 copay
Tier	Two-month supply
1 (Preferred Generic)	\$0 copay
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$70 copay
Tier	Three-month supply
1 (Preferred Generic)	\$0 copay (100-day supply)
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$105 copay

PRESCRIPTION DRUG BENEFITS (PART D)

Standard Retail Cost-sharing

	AmeriHealth Medicare Core PPO
Tier	One-month supply
1 (Preferred Generic)	\$9 copay
2 (Generic)	\$20 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	25% coinsurance
Insulin (Tiers 3, 4, and 5)	\$35 copay
Tier	Two-month supply
1 (Preferred Generic)	\$18 copay
2 (Generic)	\$40 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$70 copay
Tier	Three-month supply
1 (Preferred Generic)	\$18 copay (100-day supply)
2 (Generic)	\$40 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$105 copay

PRESCRIPTION DRUG BENEFITS (PART D)

Mail-order Cost-sharing

	AmeriHealth Medicare Core PPO
Tier	One-month supply
1 (Preferred Generic)	\$0 copay
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	25% coinsurance
Insulin (Tiers 3, 4, and 5)	\$35 copay
Tier	Two-month supply
1 (Preferred Generic)	\$0 copay
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$70 copay
Tier	Three-month supply
1 (Preferred Generic)	\$0 copay (100-day supply)
2 (Generic)	\$0 copay
3 (Preferred Brand)	24% coinsurance
4 (Non-Preferred)	25% coinsurance
5 (Specialty)	Not Applicable
Insulin (Tiers 3 and 4)	\$70 copay

You may fill your prescriptions at network retail pharmacies (preferred or standard) and mail-order pharmacies. Tier 1 and 2 prescriptions (which include most generic drugs) will have \$0 copays when filled at preferred pharmacies or through mail order.

Your cost-sharing may change depending on the pharmacy you choose, if you purchase a long-term supply (up to 100 days) of a drug, when you move into each stage of your Part D benefits, or if you reside in a long-term care facility.

Please call us or see the plan's *Evidence of Coverage* on our website at [amerihealthmedicare.com](https://www.amerihealthmedicare.com) for complete information about your costs for covered drugs.

Catastrophic Coverage Stage

After reaching the annual maximum of \$2,400 in out-of-pockets costs, you pay \$0 for covered drugs.

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SECTION V - SUMMARY OF BENEFITS

OTHER MEDICAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Telemedicine Visits	<u>In-Network and Out-of-Network:</u> \$0 copay for general medical visits focused on urgent-care like visits. \$0 copay to talk to a therapist or psychiatrist by appointment for depression, anxiety, stress and more. \$0 copay for dermatology visits focused to diagnose and treat skin conditions like eczema, psoriasis, acne and more. Teladoc must be used for telemedicine visits. Members can access Teladoc by toll-free phone, secure video chat, or through Teladoc's secure website/mobile platform, 24/7, 365 days per year.
Additional Telehealth (Primary care physician, specialist, physical therapy, occupational therapy, speech therapy, and other health care professionals)	<u>In-Network:</u> Primary care physician: \$0 copay per visit. Specialist: \$55 copay per visit. Physical, and speech therapy: \$55 copay per visit. Occupational therapy: \$35 copay per visit. Other health care professional: \$55 copay per visit. Not all telehealth services may be covered.
Chiropractic Services	Medicare-covered <u>In-Network:</u> \$15 copay per visit for spinal manipulation. <u>Out-of-Network:</u> 50% of the total cost.

OTHER MEDICAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Chiropractic Services (continued)	Routine Care <u>In-Network:</u> \$15 copay per visit (up to 6 visits combined in and out of network per year). <u>Out-of-Network:</u> 50% of the total cost. Routine visits do not count toward the annual MOOP amount.
Acupuncture	Medicare-covered <u>In-Network:</u> \$15 copay per visit (up to 12 visits in 90 days; 8 additional if determined that progress is made). <u>Out-of-Network:</u> 50% of the total cost. Routine Care <u>In-Network:</u> \$15 copay per visit (up to 6 visits each year). <u>Out-of-Network:</u> 50% of the total cost. Routine visits require a diagnosis of one of the eligible conditions. Routine visits do not count toward the annual MOOP amount.
Podiatry Services	Medicare-covered <u>In-Network:</u> \$20 copay per visit. <u>Out-of-Network:</u> 50% of the total cost. Routine Care <u>In-Network:</u> \$20 copay per visit (up to 6 visits combined in and out of network per year).

OTHER MEDICAL BENEFITS

Benefits/Services	AmeriHealth Medicare Core PPO
Podiatry Services (continued)	<u>Out-of-Network:</u> 50% of the total cost. Routine visits do not count toward the annual MOOP amount.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Help Team representative at **1-866-569-5190 (TTY/TDD: 711)**.

Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [amerihealthmedicare.com](https://www.amerihealthmedicare.com) or call **1-866-569-5190 (TTY/TDD: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

DISCLAIMERS

For updated information regarding plan providers, visit our website at [amerihealthmedicare.com](https://www.amerihealthmedicare.com), or call our Member Help Team at **1-866-569-5190 (TTY/TDD: 711)**, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from January 1 through September 30, your call may be sent to voicemail.

If you are not yet a member and have questions, please call **1-800-898-3492 (TTY/TDD: 711)**, seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from January 1 through September 30, your call may be sent to voicemail. By calling this number you will be directed to a licensed sales agent.

AmeriHealth Insurance Company of New Jersey offers PPO plans with a Medicare contract. Enrollment in AmeriHealth PPO plans depends on contract renewal.

Benefits underwritten by AmeriHealth Insurance Company of New Jersey. TruHearing® is a registered trademark of TruHearing, Inc.

Vision benefits are underwritten by AmeriHealth Insurance Company Of New Jersey and administered by Davis Vision.

An affiliate of AmeriHealth has a financial interest in Visionworks.

AmeriHealth Medicare Dental Network administered by Dominion Dental Services, Inc.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Telemedicine is provided by Teladoc.

One Pass is a voluntary program offered by an independent company. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

To receive this document in an alternate format such as Braille, large print, or audio, please call **1-800-898-3492 (TTY/TDD: 711)** (non-members) (by calling this number you will be directed to a licensed sales agent) or **1-866-569-5190 (TTY/TDD: 711)** (members).

This information is not a complete description of benefits. Contact **1-800-898-3492 (TTY/TDD: 711)** for more information.

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 بصيغ 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 aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર 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でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

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 yánílti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahj'í bee adahodooníí diné bich'í'í anídahazt'í'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaígíí aldó' t'áá jiik'eh hóló. Kohj'í 1-800-275-2583 (TTY: 711) hodílinih doodago nika'análawo'í bich'í'í hanidziíh.

Pennsilfaanisch-Deutsch: WICHDIICH: Wann du Deutsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాషాసహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న పాఠ్యాబ్దాలలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్కు కాల్ చేయండి లేదా మీ ప్రొవైడర్తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÌ: Tí ó bá nsọ Yorùbá, àwọn isẹ àtìlẹhin èdè lófèṣẹ wà láàrọwọ́tó rẹ. Àwọn isẹ àtìlẹhin irànlọwọ́ tò yẹ láti pèsè lówífúnni ní ọ̀nà irááyèsì kíka wà láàrọwọ́tó bakanna lófèṣẹ. Pẹ 1-800-275-2583 (TTY: 711) tàbí kí 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.

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