



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.amerhealthnj.com/SGBooklet](http://www.amerhealthnj.com/SGBooklet) or by calling 1-888-YOUR-AH1 (TTY:711).

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For participating providers \$0 person / \$0 family. Deductible may not apply to all services. See your cost information starting on page 2 for specific details.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$4,000 person / \$8,000 family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.amerhealthnj.com/provider_finder">www.amerhealthnj.com/provider_finder</a> or call 1-888-YOUR-AH1 (TTY:711) for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		an In-Network Provider	an Out-Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copayment (copay)	Not Covered	-----none-----
	Specialist visit	\$40 copay	Not Covered	-----none-----
	Other practitioner office visit	\$40 copay	Not Covered	Therapeutic manipulations: 30 visits per calendar year.
	Preventive care / screening / immunization	No Charge	Not Covered	Visit limits may apply to routine gynecological exam.
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay(X-Ray)/ No Charge(Blood Work)	not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 copay	Not Covered	Prior authorization is required.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.amerhealthnj.com/precert">www.amerhealthnj.com/precert</a>	Generic drugs	\$7 copay	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Preferred brand drugs	\$35 copay	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Non-preferred brand drugs	\$50 copay	Not Covered	Prior authorization may be required on some drugs. Covers up to a 90 day supply.
	Specialty drugs	\$50 copay	Not Covered	This applies to oral or injectable self-administered Specialty Drugs which are covered under the Prescription Drug Plan. Covers up to a 90 day supply. Prior authorization and/or dispensing limits may apply. Other Specialty Drugs and infusion therapy drugs may be covered under your medical benefits plan as stated within your Policy and/or Drug Rider information. A complete list of drugs requiring Prior authorization is available at <a href="http://www.amerhealthnj.com/precert">www.amerhealthnj.com/precert</a>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Prior authorization is required for certain services.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		an In-Network Provider	an Out-Of Network Provider	
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization is required for certain services.
If you need immediate medical attention	Emergency room services	\$100 copay	Covered at in-network level	-----none-----
	Emergency medical transportation	No Charge	Covered at in-network level	-----none-----
	Urgent care	\$65 copay	Covered at in-network level	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physicians office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior authorization is required.
	Physician/surgeon fee	No Charge	Not Covered	Prior authorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay	Not Covered	-----none-----
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Prior authorization is required.
	Substance abuse disorder outpatient services	\$40 copay	Not Covered	-----none-----
	Substance abuse disorder inpatient services	No Charge	Not Covered	Prior authorization is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	-----none-----
	Delivery and all inpatient services	No Charge	Not Covered	Prior notification requested.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization is required. 60 visits per calendar year.
	Rehabilitation services	\$40 copay	Not Covered	Physical Therapy/ Occupational Therapy: 30 visits (combined) per calendar year; Speech Therapy/Cognitive Therapy: 30 visits (combined) per calendar year.
	Habilitation services	\$40 copay	Not Covered	Physical Therapy/ Occupational Therapy: 30 visits (combined) per calendar year; Speech Therapy/Cognitive Therapy: 30 visits (combined) per calendar year. Visit limits do not apply for Treatment of Autism.
	Skilled nursing care	No Charge	Not Covered	Prior authorization is required.
	Durable medical equipment	50%	Not Covered	Prior authorization is required for selected items.
	Hospice service	No Charge	Not Covered	Prior authorization is required.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Pediatric Vision; Once every calendar year.
	Glasses	No Charge	Not Covered	Pediatric Vision; Once every calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		an In-Network Provider	an Out-Of Network Provider	
	Dental check-up	Not Covered	Not Covered	Not Covered

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Long-term care</li> <li>• Routine foot care</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Non-emergency care when traveling outside the U.S. (For details, see <a href="http://www.amerihhealthnj.com">www.amerihhealthnj.com</a>)</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Routine eye care (Adult)</li> </ul> |
|--|--|---|

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Abortions</li> <li>• Hearing Aids (covered for members age 15 and younger)</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility Treatment (limited to artificial insemination; requires pre approval)</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Private Duty Nursing Care (covered under Home Health Care)</li> </ul> |
|--|--|---|

### Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact us at 888-YOUR-AH1 (TTY:711) or contact the New Jersey Department of Banking and Insurance at 800-446-7467.

### Your Grievance and Appeals Rights:

If your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements or if you are dissatisfied with a denial of coverage for claims under your plan, you may contact AmeriHealth NJ at 1-877-585-5731 TTY 711. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the New Jersey Department of Banking and Insurance can also provide assistance. Please contact them via the Internet: <http://www.state.nj.us/dobi/consumer.htm>, by email: [ombudsman@dobi.state.nj.us](mailto:ombudsman@dobi.state.nj.us), or by telephone: 1-888-393-1062.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan Pays \$7,280
- Patient Pays \$260

#### Sample Care Costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient Pays

Deductibles	\$0
Copays	\$110
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$260</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan Pays \$3,900
- Patient Pays \$1,500

#### Sample Care Costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient Pays

Deductibles	\$0
Copays	\$1,420
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,500</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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# Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

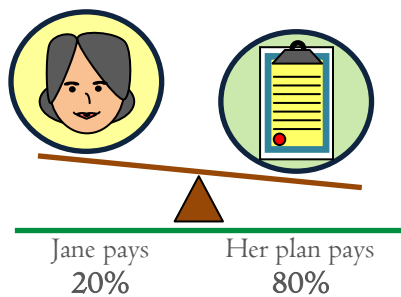
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

## Complications of Pregnancy

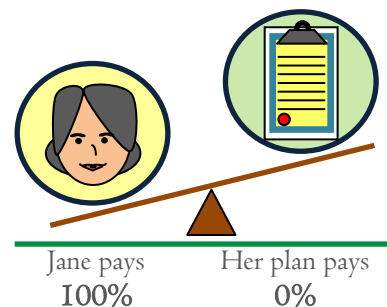
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## Durable Medical Equipment (DME)

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

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** you get in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.



## Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

## Grievance

A complaint that you communicate to your health insurer or **plan**.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

## Home Health Care

Health care services a person receives at home.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

## In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

## Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

## Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network Co-insurance

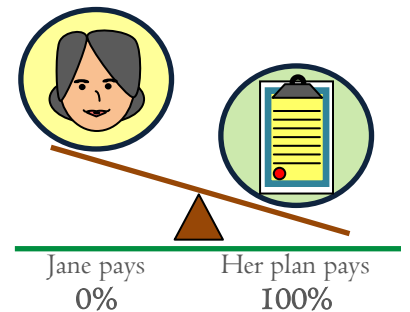
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

## Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or **plan** doesn't cover. Some health insurance or **plans** don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

## Physician Services

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

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

# How You and Your Insurer Share Costs - Example

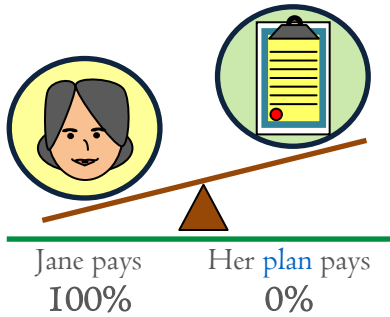
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Coverage  
Period

December 31<sup>st</sup>  
End of Coverage Period



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

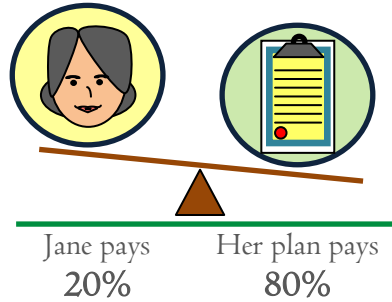
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



## Jane reaches her \$1,500 deductible, co-insurance begins

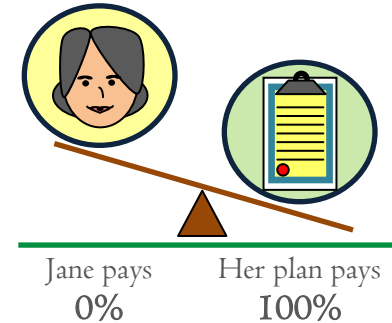
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more costs



## Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200

## Language Access Services

If you, or someone you're helping, has questions about AmeriHealth New Jersey, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-968-7241 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de AmeriHealth New Jersey, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-968-7241 TTY 711.

如对 AmeriHealth New Jersey 有任何问题, 请您或您所帮助的人联系我们提供的免费多语言信息服务。翻译服务请拨打 1-888-968-7241。

AmeriHealth New Jersey 와 관련하여 궁금한 사항이 있으신 경우 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-888-968-7241 로 전화해 주십시오.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o AmeriHealth New Jersey, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-968-7241.

જો તમને અથવા તમે કોઈને મદદ કરી રહ્યા તેમાંથી કોઈને AmeriHealth New Jersey વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-888-968-7241 પર કોલ કરો.

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu AmeriHealth New Jersey, mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-888-968-7241.

Se tu o qualcuno che stai aiutando avete domande su AmeriHealth New Jersey, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-888-968-7241.

إذا كان لديك أو لدى شخص تساعد أسئلة بخصوص AmeriHealth New Jersey، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-888-968-7241.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa AmeriHealth New Jersey, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-888-968-7241.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы AmeriHealth New Jersey, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-968-7241.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan AmeriHealth New Jersey, ou gen dwa pou resevwa èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-888-968-7241.

यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के AmeriHealth New Jersey के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए, 1-888-968-7241 पर कॉल करें।

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về AmeriHealth New Jersey, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-888-968-7241.

Si vous, ou quelqu'un que vous aidez, a des questions à propos d'AmeriHealth New Jersey, vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-888-968-7241.

اگر آپ، یا کوئی شخص جس کی آپ مدد کر رہے ہیں، کو AmeriHealth New Jersey کے بارے میں سوالات کرنے ہیں تو آپ کو بلا معاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، 1-888-968-7241 پر کال کریں۔

Díí kwe'é atah nílínígíí AmeriHealth New Jersey haada yit'éego bína ídíłkídogo éi doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkídogo bee ná ahóót'i'díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo búáh ílínígóó. Ata' halne'ígíí kojí' bich'í' hodíłnínih 1-888-968-7241.

ご本人やお客様の周りの人が、AmeriHealth New Jersey についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用する方は、1-888-968-7241 までお電話ください。

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über AmeriHealth New Jersey haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-968-7241 an.

اگر شما یا شخصی کہ به وی کمک می کنید، در رابطه با AmeriHealth New Jersey سوالی دارید، این حق برای شما محفوظ است کہ بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-888-968-7241 تماس حاصل فرمایید.

## **Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services**

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

AmeriHealth New Jersey:

- 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 our Civil Rights Coordinator. If you believe that AmeriHealth New Jersey has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have four ways to file a grievance:

- By mail :  
AmeriHealth New Jersey  
Attn: Civil Rights Coordinator  
1901 Market Street  
Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY:711)
- By fax: 215-761-0245
- By email: [CivilRightsCoordinator@amerihealth.com](mailto:CivilRightsCoordinator@amerihealth.com)

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.