



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, visit

<https://ambetter.pahealthwellness.com/2022-brochures.html>, or call 1-833-510-4727 (Relay 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-833-510-4727 (Relay 711) to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$7,200 individual / \$14,400 family.   | 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> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services, primary care and <a href="#">urgent care</a> office visits, children's eye exam and glasses, and generic drugs 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> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$8,400 individual / \$16,800 family. Not applicable for <a href="#">out-of-network providers</a> .   | 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.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</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> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://ambetter.pahealthwellness.com/findadoc">https://ambetter.pahealthwellness.com/findadoc</a> or call 1-833-510-4727 (Relay 711) for a list of <a href="#">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 <a href="#">plan's 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 <a href="#">provider's</a> 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</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   |
|--|--|--|--|--|
|  |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | 50% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply  | Not covered  | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.  |
|  | <a href="#">Specialist</a> visit                       | 50% <a href="#">Coinsurance</a>  | Not covered  | Covered No Limit.  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply   | Not covered  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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)    | 50% <a href="#">Coinsurance</a> for laboratory & professional services<br><br>50% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging<br><br>50% <a href="#">Coinsurance</a> for laboratory & professional services and x-ray & diagnostic imaging at other places of service | Not covered  | Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.<br><br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
|  | Imaging (CT/PET scans, MRIs)                           | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.   |
| If you need drugs to treat your illness or condition                   | Generic drugs (Tier 1)                                 | Preferred Generic Retail: \$5 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply<br><br>Generic Retail: \$25 <a href="#">Copay</a> / prescription;  | Not covered  | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.  |

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| More information about <a href="https://ambetter.pahealthwellness.com/2022formulary">prescription drug coverage</a> is available at <a href="https://ambetter.pahealthwellness.com/2022formulary">https://ambetter.pahealthwellness.com/2022formulary</a> . |  | <a href="#">deductible</a> does not apply  |  |   |
|   | Preferred brand drugs (Tier 2)                   | Retail: 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount. |
|   | Non-preferred brand drugs (Tier 3)               | Retail: 50% <a href="#">Coinsurance</a>  | Not covered  |   |
|   | <a href="#">Specialty drugs</a> (Tier 4)         | Retail: 50% <a href="#">Coinsurance</a>  | Not covered  |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.  |
|   | Physician/surgeon fees                           | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.  |
| If you need immediate medical attention   | <a href="#">Emergency room care</a>              | 50% <a href="#">Coinsurance</a>  | 50% <a href="#">Coinsurance</a>                    | Covered No Limit.   |
|   | <a href="#">Emergency medical transportation</a> | 50% <a href="#">Coinsurance</a>  | 50% <a href="#">Coinsurance</a>                    | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.  |
|   | <a href="#">Urgent care</a>                      | \$60 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                | Not covered  | Covered No Limit.   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.  |
|   | Physician/surgeon fees                           | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.  |
| If you need mental health, behavioral health, or substance abuse services   | Outpatient services                              | 50% <a href="#">Coinsurance</a> /Office Visit; 50% <a href="#">Coinsurance</a> for other outpatient services | Not covered  | Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).  |
|   | Inpatient services                               | 50% <a href="#">Coinsurance</a>  | Not covered  | Prior authorization may be required. Covered No Limit.  |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|--|---|
|  |   | Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |   |
| If you are pregnant  | Office visits                             | 50% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply | Not covered  | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | 50% <a href="#">Coinsurance</a>   | Not covered  | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).   |
|  | Childbirth/delivery facility services     | 50% <a href="#">Coinsurance</a>   | Not covered  | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 50% <a href="#">Coinsurance</a>   | Not covered  | Prior authorization may be required. Limited to 60 visits per year.   |
|  | <a href="#">Rehabilitation services</a>   | 50% <a href="#">Coinsurance</a>   | Not covered  | Prior authorization may be required. Limited to 30 visits per year for Speech Therapy; a combined limit of 30 visits per year applies for Physical & Occupational Therapy; a combined limit of 36 visits per year applies for Cardiac, Pulmonary & Respiratory Therapy. Note: These limits do not apply when provided for a mental health/substance use disorder diagnosis.   |
|  | <a href="#">Habilitation services</a>     | 50% <a href="#">Coinsurance</a>   | Not covered  | Prior authorization may be required. Limited to 30 visits per year for Speech Therapy; a combined limit of 30 visits per year applies for Physical & Occupational Therapy; a  |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                    |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |  |
|  |   |  |  | combined limit of 36 visits per year applies for Cardiac, Pulmonary & Respiratory Therapy. Note: These limits do not apply when provided for a mental health/substance use disorder diagnosis. |
|  | <a href="#">Skilled nursing care</a>      | 50% <a href="#">Coinsurance</a>                      | Not covered  | Prior authorization may be required. Limited to 120 days per year.   |
|  | <a href="#">Durable medical equipment</a> | 50% <a href="#">Coinsurance</a>                      | Not covered  | Prior authorization may be required. Covered No Limit.   |
|  | <a href="#">Hospice services</a>          | 50% <a href="#">Coinsurance</a>                      | Not covered  | Prior authorization may be required. Respite care - limited to a maximum of 7 days every 6 months.   |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply | Not covered  | Limited to 1 exam per year.  |
|  | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply | Not covered  | Limited to 1 item per year.  |
|  | Children's dental check-up                | Not covered  | Not covered  | -----None-----   |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                    |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>Dental (Children)</li> <li>Hearing aids</li> <li>Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Weight loss programs</li> </ul> |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care (Limited to 20 visits per year)
- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year.)
- Infertility treatment (Artificial insemination is covered; IVF, GIFT and ZIFT are excluded)
- Routine eye care (Adult-one visit & one item per year. Dollar limits apply)
- Routine foot care (Coverage is limited to diabetes care only)

**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: Ambetter from PA Health & Wellness at 1-833-510-4727 (Relay 711); Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17111, Phone No. 1-877-881-6388. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), 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 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: Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17111, Phone No. 1-877-881-6388. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-510-4727 (Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-510-4727 (Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-510-4727 (Relay 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-510-4727 (Relay 711).

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



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$7,100        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,300        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,460</b> |

### 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> | \$7,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,300        |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$4,820</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 50%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

|                              |   |
|------------------------------|---|
| <b>Spanish:</b>              | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from PA Health & Wellness, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-510-4727 (Relay 711).   |
| <b>Chinese:</b>              | 如果您，或是您正在協助的對象，有關於Ambetter from PA Health & Wellness方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話1-833-510-4727 (Relay 711)。  |
| <b>Vietnamese:</b>           | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from PA Health & Wellness, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-510-4727 (Relay 711).   |
| <b>Russian:</b>              | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from PA Health & Wellness, вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-510-4727 (Relay 711). |
| <b>Pennsylvania Dutch:</b>   | Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from PA Health & Wellness, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-833-510-4727 (Relay 711).                                       |
| <b>Korean:</b>               | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from PA Health & Wellness,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-510-4727 (Relay 711)로 전화하십시오.   |
| <b>Italian:</b>              | Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from PA Health & Wellness, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l' 1-833-510-4727 (Relay 711).  |
| <b>Arabic:</b>               | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from PA Health & Wellness، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ. 1-833-510-4727 (Relay 711).   |
| <b>French:</b>               | Si vous-même ou une personne que vous aidez avez des questions à propos Ambetter from PA Health & Wellness, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-510-4727 (Relay 711).   |
| <b>German:</b>               | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from PA Health & Wellness, hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-510-4727 (Relay 711).] an.                                 |
| <b>Gujarati:</b>             | જ તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from PA Health & Wellness, વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-510-4727 (Relay 711) ઉપર કોલ કરો.  |
| <b>Polish:</b>               | Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów za pośrednictwem Ambetter from PA Health & Wellness, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-833-510-4727 (Relay 711).                                  |
| <b>French Creole:</b>        | Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from PA Health & Wellness, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-833-510-4727 (Relay 711).  |
| <b>Mon-Khmer, Cambodian:</b> | ប្រសិនបើអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងកែច្នៃមានបញ្ហាអំពី Ambetter from PA Health & Wellness អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសាខ្មែរដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែភាសាលេខ 1-833-510-4727 (Relay 711)។   |
| <b>Portuguese:</b>           | Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from PA Health & Wellness, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-833-510-4727 (Relay 711).   |



### Statement of Non-Discrimination

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

Ambetter from PA Health & Wellness:

- 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 Ambetter from PA Health & Wellness at 1-833-510-4727 (Relay 711).

If you believe that Ambetter from PA Health & Wellness 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: Ambetter from PA Health & Wellness, Attn: Grievances and Appeals Department, PO Box 10341 Van Nuys CA, 91410, 1-833-510-4727 (Relay 711), Fax, 1-833-886-7956. You can file a grievance by mail or fax. If you need help filing a grievance, Ambetter from PA Health & Wellness 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>.