Ambetter from Western Sky Community Care
Complete Gold On Exchange: Standard Gold On Exchange Plan

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.westernskycommunitycare.com/2024-brochures.html, or call 1-833-945-2029 (TTY 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 1-833-945-2029 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,850 individual / $3,700 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, primary care, specialist, and urgent care office visits, lab-work, generic and preferred brand drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $7,850 individual / $15,700 family. Not applicable for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See the Bronze|Silver|Gold NM	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for

	network at https://ambetter.westernskycommunitycare.com/findadoc or call 1-833-945-2029 (TTY 711) for a list of network providers.	the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay / visit; deductible does not apply	Not covered	Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full, deductible does not apply.
	Specialist visit	$35 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 Copay / visit; deductible does not apply for laboratory & professional services 20% Coinsurance for x-ray & diagnostic imaging 20% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Prior authorization not required for gynecological or obstetrical diagnostic ultrasounds. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. Testing and delivery of health care services for COVID-19 are cost share free. See your policy for more details. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Failure to obtain prior authorization for any service that requires prior authorization may result in a denial of benefits.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambetter.westernskycommunitycare.com/2024formulary**.	Generic drugs (Tier 1)	Preferred Generic Retail: $3 Copay / prescription; deductible does not apply Generic Retail: $15 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. Insulin or medically necessary alternative will not exceed a total of twenty-five dollars ($25.00) per thirty-day supply. Note: Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating pharmacy. See your plan's covered drug list for details.
	Preferred brand drugs (Tier 2)	Retail: $30 Copay / prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: 30% Coinsurance	Not covered	
	Specialty drugs (Tier 4)	Retail: 30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. Insulin or medically necessary alternative will not exceed a total of twenty-five dollars ($25.00) per thirty-day supply. Note: Certain prescription drugs for preventive care, the treatment of mental illness, behavioral health, or substance abuse disorders will be covered at No Charge to you, when obtained from a participating pharmacy. See your plan's covered drug list for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Covered No Limit. Balance billing is not allowed for out-of-network care.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport. However, all non-emergent transport requires prior authorization. Balance billing is not allowed for out-of-network care.
	Urgent care	$35 Copay / visit; deductible does not apply	$35 Copay / visit; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) (Primary Care Provider (PCP) and other practitioner visits do not require prior authorization).
	Inpatient services	No charge; deductible does not apply	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$15 Copay / visit; deductible 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. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% Coinsurance	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 100 visits per year.
	Rehabilitation services	Outpatient: $15 Copay / visit; deductible does not apply Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: $15 Copay / visit; deductible does not apply Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; deductible 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (Limited to 20 visits per year. Note: Acupuncture limits do not apply when services are provided for habilitative or rehabilitative purposes.)
- Bariatric surgery
- Chiropractic care (Limited to 20 visits per year. Note: Chiropractic limits do not apply when services are provided for habilitative or rehabilitative purposes.)
- Hearing aids (Limited to 1 hearing aid per ear every 3 years.)
- Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)
- Routine foot care

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 Western Sky Community Care at 1-833-945-2029 (TTY 711); Office of Superintendent of Insurance, PO Box 1689, Santa Fe, NM 87504-1689, Phone No. (855) 427-5674.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. 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.beWellnm.com or call (833) 862-3935.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Office of Superintendent of Insurance, PO Box 1689, Santa Fe, NM 87504-1689, Phone No. (855) 427-5674. Additionally, a consumer assistance program can help you file your appeal. Contact (833) 415-0566

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? **Not Applicable**.
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 1-833-945-2029 (TTY 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-945-2029 (TTY 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-945-2029 (TTY 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-945-2029 (TTY 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 plan's overall deductible	$1,850
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,850
Copayments	$300
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,610**

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

The plan's overall deductible	$1,850
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,850
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,850
Copayments	$200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

English:	If you, or someone you are helping, have questions about Ambetter from Western Sky Community Care, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-945-2029 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Western Sky Community Care y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-945-2029 (TTY 711).
Navajo:	Daa ni, doodaii la'da ni'bineesh'a dzą́ądi, be'esdzááh na'ídíkid 'aa Ambetter from Western Sky Community Care, dóó bineesh'a góó t'oo 'adee naash'ne di Bilagaana bizaad, ni be'esdzááh la' t'áá 'áko góó bil hánish'áásh dzą́ądi dóó bíka'ashkíd di nihí saad gi 'ádin t'áadoo bááhilinigoo dóó di léi na'alkid lahgo 'át'éego. Dą́ą́ ni, doodaii la'da ni'bineesh'a dzaadi, be'esdzááh la nish'j dóó/doodaii na'ach'aah 'ahooszoli eii biniishl'aah bil'alnaa'alwo, ni be'esdzááh la' t'aa 'ako góó baa yíltsóós 'ooljee'lahgo 'anaa'niil bika'iishyeed dóó tse'esgizii gi 'adin t'aadoo baahilinigoo dóó di léi na'alkid lahgo 'át'éego. Góó yíltsóós saad náánálahdéé' doodaii 'ooljee'lahgo 'anaa'niil tse'esgizii, t'aa shoodi deistse' 'Anishtah Tse'esgizii gi 1-833-945-2029 (TTY 711).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Western Sky Community Care và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-833-945-2029 (TTY 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Western Sky Community Care hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-833-945-2029 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Western Sky Community Care 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-833-945-2029 (TTY 711)。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Western Sky Community Care، ولم تكن بارعا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على (TTY 711) 1-833-945-2029.
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Western Sky Community Care에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-833-945-2029(TTY 711)번으로 가입자 서비스부에 연락해주십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Western Sky Community Care, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-945-2029 (TTY 711).
Japanese:	ご自身やあなたが介護している他の人が、Ambetter from Western Sky Community Careについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-833-945-2029 (TTY 711)のメンバーサービスにご連絡ください。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Western Sky Community Care et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-833-945-2029 (TTY 711).
Italian:	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Western Sky Community Care e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-833-945-2029 (TTY 711).

Russian:	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Western Sky Community Care, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-833-945-2029 (TTY 711).
Hindi:	अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Western Sky Community Care से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ़्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-833-945-2029 (TTY 711) पर सदस्य सेवाएं से संपर्क करें.
Persian:	اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter from Western Sky Community Care دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با خدمات اعضا به شماره (TTY 711) 1-833-945-2029 تماس بگیرید.
Thai:	หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Western Sky Community Care และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-945-2029 (TTY 711)

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Statement of Non-Discrimination

Ambetter from Western Sky Community Care is underwritten by Western Sky Community Care, Inc., which is a Qualified Health Plan issuer in the New Mexico Health Insurance Marketplace. Western Sky Community Care, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. Ambetter.WesternSkyCommunityCare.com

If you, or someone you are helping, have questions about Ambetter from Western Sky Community Care, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-945-2029 (TTY 711). If you believe that Western Sky Community Care, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-945-2029 (TTY 711). You may also submit a grievance by phone to 1-833-945-2029 (TTY 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

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