




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://ambetterhealth.com/en/wa/2026-brochures.html>, or call 1-877-687-1197 (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 1-877-687-1197 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,500 individual / \$5,000 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, <a href="#">specialist</a> , and <a href="#">urgent care</a> visits, and certain <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> (see additional information below).	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> : \$7,950 individual / \$15,900 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, health care this <a href="#">plan</a> doesn't cover, penalties for failure to obtain <a href="#">preauthorization</a> for services, costs for non-covered services, and services provided by <a href="#">out-of-network providers</a> .	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	Yes. See	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> .

Important Questions	Answers	Why This Matters:
use a <a href="#">network provider</a> ?	<a href="https://ambetterhealth.com/en/wa/fi/ndadoc">https://ambetterhealth.com/en/wa/fi/ndadoc</a> or call 1-877-687-1197 (TTY 711) for a list of <a href="#">network providers</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 (You will pay the least)	Out-of-Network Provider (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	First two visits: \$1 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply. Additional visits: \$20 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply.	Not covered	Unlimited Virtual 24/7 Care Visits received from Ambetter's <a href="#">network providers</a> covered at No Charge, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$65 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	None.
	<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)	\$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply for laboratory & professional services  \$65 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply for x-ray & diagnostic imaging  \$600 <a href="#">Copay</a> / visit for laboratory & professional services	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.  Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits.

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)	
		and x-ray & diagnostic imaging at other places of service		
	Imaging (CT/PET scans, MRIs)	30% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://ambetterhealth.com/en/wa/2026formulary">prescription drug coverage</a> is available at <a href="https://ambetterhealth.com/en/wa/2026formulary">https://ambetterhealth.com/en/wa/2026formulary</a>	Generic drugs (Tier 1)	Retail: \$24 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	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.
	Preferred brand drugs (Tier 2)	Retail: \$75 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	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: \$250 <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 30 days through mail order.
	<a href="#">Specialty drugs</a> (Tier 4)	Retail: \$250 <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 30 days through mail order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$600 <a href="#">Copay</a> / visit	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	\$200 <a href="#">Copay</a> / visit	Not covered	Prior authorization may be required. Covered No Limit.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$800 <a href="#">Copay</a> / visit	\$800 <a href="#">Copay</a> / visit	Covered No Limit. For emergency services in Washington state and out-of-state, only in- <a href="#">network cost sharing</a> amounts are applicable; <a href="#">providers</a> /hospitals aren't permitted to balance bill members - despite <a href="#">network</a> status. (See note on <a href="#">balance billing</a> above this chart.)
	<a href="#">Emergency medical transportation</a>	\$325 <a href="#">Copay</a> / trip; <a href="#">deductible</a> does not apply	\$325 <a href="#">Copay</a> / trip; <a href="#">deductible</a> does not apply	Covered No Limit. In- <a href="#">network cost sharing</a> applies to air and ground ambulance services in Washington state and out-of-state air ambulance services. <a href="#">Providers</a> , including air ambulance and ground

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)	
				ambulance service organizations, aren't permitted to balance bill for these emergency services. Water ambulance services are excluded from federal and state <a href="#">balance billing</a> prohibition requirements and may balance bill for emergency services. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	<a href="#">Urgent care</a>	\$65 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$800 <a href="#">Copay</a> / day, up to 5 days	Not covered	Prior authorization may be required. The per day <a href="#">copayment</a> is limited to 5 copayments per stay.
	Physician/surgeon fees	Included in facility fee	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First two office visits: \$1 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply. Additional office visits: \$20 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply. Other Outpatient Services: \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	\$800 <a href="#">Copay</a> / day, up to 5 days	Not covered	Prior authorization may be required. The per day <a href="#">copayment</a> is limited to 5 copayments per stay.
If you are pregnant	Office visits	No charge; <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

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)	
				services or sick newborns. 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 that have <a href="#">cost-sharing</a> found under a different benefit category, such as diagnostic tests like ultrasounds. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	Included in facility fee	Not covered	Prior authorization may be required. The per day inpatient <a href="#">copayment</a> is limited to 5 copayments per stay. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services that have <a href="#">cost-sharing</a> found under a different benefit category, such as diagnostic tests like ultrasounds. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery facility services	\$800 <a href="#">Copay</a> / day, up to 5 days	Not covered	Prior authorization may be required. The per day inpatient <a href="#">copayment</a> is limited to 5 copayments per stay. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services that have <a href="#">cost-sharing</a> found under a different benefit category, such as diagnostic tests like ultrasounds. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <a href="#">Copay</a> / day; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Limited to 130 visits per year.
	<a href="#">Rehabilitation services</a>	Outpatient: \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply Inpatient: \$800 <a href="#">Copay</a> / day, up to 5 days	Not covered	Outpatient: Prior authorization may be required after 6th visit. Limited to 25 outpatient visits per year. Inpatient: Prior authorization may be required. Limited to 30 inpatient days per year. The per day <a href="#">copayment</a> is limited to 5 copayments per stay. Note: Outpatient and inpatient limits do not apply when provided for a mental health/substance use disorder diagnosis.
	<a href="#">Habilitation services</a>	Outpatient: \$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply Inpatient: \$800 <a href="#">Copay</a> / day, up to 5 days	Not covered	Outpatient: Prior authorization may be required after 6th visit. Limited to 25 outpatient visits per year. Inpatient: Prior authorization may be required. Limited to 30 inpatient days per year. The per day <a href="#">copayment</a> is limited to 5

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)	
				copayments per stay. Note: Outpatient and inpatient limits do not apply when provided for a mental health/substance use disorder diagnosis.
	<a href="#">Skilled nursing care</a>	\$800 <a href="#">Copay</a> / day	Not covered	Prior authorization may be required. Limited to 60 days per year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	<a href="#">Hospice services</a>	\$30 <a href="#">Copay</a> / day; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Limited to 14 days per lifetime for respite care covered in conjunction with <a href="#">hospice services</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 item per year. Limited to one frame and one pair (two lenses) per calendar year or contacts in lieu of glasses.
	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>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment (except for Artificial Insemination)</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (10 visits/year)</li> <li>Hearing aids (Limited to 1 per ear every 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> </ul>

**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: Office of the Insurance Commissioner Phone No. 1-800-562-6900; Ambetter from Coordinated Care Corporation at 1-877-687-1197 (TTY 711); 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.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Washington State Office of the Insurance Commissioner, Phone: 1-800-562-6900.

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

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

**Does this plan meet the Minimum Value Standards? 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 1-877-687-1197 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1197 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-687-1197 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-687-1197 (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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">coinsurance</a>	30%

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,960</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">coinsurance</a>	30%

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">coinsurance</a>	30%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

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



<b>Korean:</b>	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Coordinated Care Corporation에 대한 질문이 있는 경우 영어에 능숙하지 않으면 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 1-877-687-1197 (TTY 711)번으로 가입자 서비스부에 연락해 주십시오.
<b>Laotian:</b>	ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter from Coordinated Care Corporation, ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເຕີມບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໄດ້ທີ່ 1-877-687-1197 (TTY 711).
<b>Pashto:</b>	که تاسو، یا هغه څوک چې تاسو ورسره مرسته کوئ، د Ambetter from Coordinated Care Corporation په اړه پوښتنې لری او په انګلیسي ژبه کې مهارت نه لری، تاسو حق لری چې په خپله ژبه کې پرته له لګښت او په وخت سره مرسته او معلومات ترلاسه کړئ. که تاسو، یا هغه څوک چې تاسو ورسره مرسته کوئ، د اوریدو او/یا د لیدلو ستونزه لری چې د اړیکو مخه نیسي، تاسو حق لری چې مرستندویه مرستې او خدمات په وړیا توګه او په وخت سره ترلاسه کړئ. د ژباړې یا مرستندویه خدماتو ترلاسه کولو لپاره، مهرباني وکړئ د غړو خدماتو سره په 1-877-687-1197 (TTY 711) اړیکه ونیسی.
<b>Portuguese:</b>	Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Coordinated Care Corporation e não falar inglês, tem direito a obter ajuda e informações no seu idioma, sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem direito a receber equipamentos ou serviços de assistência, sem qualquer custo e de forma atempada. Para ter acesso a traduções ou a serviços de assistência, contacte os "Member Services" (Serviços de Membros) através do número 1-877-687-1197 (TTY 711).
<b>Punjabi:</b>	ਜੇ ਤੁਸੀਂ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ Ambetter from Coordinated Care Corporation ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਅਤੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਵਿੱਚ ਮੁਹਾਰਤ ਨਹੀਂ ਰੱਖਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਅਤੇ ਸਮੇਂ ਸਿਰ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਸੁਣਨ ਅਤੇ/ਜਾਂ ਦੇਖਣ ਸੰਬੰਧੀ ਕੋਈ ਸਮੱਸਿਆ ਹੈ, ਜੇ ਸੰਚਾਰ ਵਿੱਚ ਰੁਕਾਵਟ ਪਾਉਂਦੀ ਹੈ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਅਤੇ ਸਮੇਂ ਸਿਰ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਅਨੁਵਾਦ ਜਾਂ ਸਹਾਇਕ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-877-687-1197 (TTY 711) 'ਤੇ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।
<b>Russian:</b>	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Coordinated Care Corporation, 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 по номеру 1-877-687-1197 (TTY 711).
<b>Somali:</b>	Haddii adiga, ama qof aad caawinaysaa, uu qabo su'aalo ku saabsan Ambetter from Coordinated Care Corporation, oo aanu si wanaagsan ugu hadal Ingiriisiga, waxaad xaq u leedahay inaad hesho caawimo iyo macluumaad ah luqaddaada oo aan kharash ahayn iyo wakhti habboon. Haddii adiga, ama qof aad caawinaysaa, aad qabtaan xaalado maqalka ah iyo/ama araga ah oo xanibta wada xidhiidhka, waxaad xaq u leedahay inaad hesho kaalmada wada xidhiidhka iyo adeegyada oo aan kharash kugu joogin qaab wakhti habboon ah. Si aad u hesho turjumaad iyo adeegyada kaalmada wada xidhiidhka, fadlan la xidhiidh Adeegyada Xubinta lambarka 1-877-687-1197 (TTY 711).
<b>Spanish:</b>	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Coordinated Care Corporation 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 1-877-687-1197 (TTY 711).

<b>Tagalog:</b>	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care Corporation, 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 pannikin 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 pagsasalín o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-877-687-1197 (TTY 711).
<b>Tigrigna:</b>	ባዕልኻ ወይ ንስኻ እትሕግዝ ሰብ ብዛዕባ ኣብ ትሕቲ Ambetter from Coordinated Care Corporation ዝመሓደር Ambetter ሕቶታት እንተልዮምኹም፣ ግን ከእ ናይ ቋንቋ ኢንግሊሽ ብቕዓት እንድሕር ዝጎድለኩም ከይኮኑ፣ ኣገዝን ኣበሬታን ብቋንቋኹም፣ ብናጻን ኣብ ትኽክለኛ እዋንን ክትረኽቡ መሰል ኣለኩም። ባዕልኻ ወይ ንስኻ እትሕግዝ ሰብ ክትረዳዳኡ ዝዕንቅፍ ናይ ምስማዕ ወይ ምርኣይ ጸገም እንተልዩኩም፣ ብናጻን ኣብ ሰዓቱን መስምጺ/መርኣዩ ኣገዛትን ኣገልግሎታትን ክትረኽቡ መሰል ኣለኩም። ናይ ትርጉም ወይ ድማ መስምጺ/መርኣዩ ኣገዛት ንምርካብ፣ በጃኻ ምስ ናይ ኣባላት ኣገልግሎታት ብ 1-877-687-1197 (TTY 711) ተራኽቡ።
<b>Ukrainian:</b>	Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Coordinated Care Corporation, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв'яжіться зі Службою обслуговування учасників за номером 1-877-687-1197 (TTY 711).
<b>Vietnamese:</b>	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Coordinated Care Corporation 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 1-877-687-1197 (TTY 711).



### Statement of Non-Discrimination

Ambetter from Coordinated Care Corporation complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Ambetter from Coordinated Care does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Ambetter from Coordinated Care:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Ambetter from Coordinated Care at 1-877-687-1197 (TTY 711).

If you believe that Ambetter from Coordinated Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance with: Ambetter from Coordinated Care, 1557 Coordinator, P.O. Box 31384, Tampa, FL 33631, 1-855-577-8234 (TTY 711), Fax 1-866-388-1769, or email [SM\\_Section1557Coord@centene.com](mailto:SM_Section1557Coord@centene.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Coordinated Care 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>.
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineServices/cc/pub/complaintinformation.aspx>.

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### Declaración de no discriminación

Ambetter from Coordinated Care Corporation cumple las leyes federales y las leyes del estado de Washington vigentes sobre derechos civiles y no discrimina por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género. Ambetter from Coordinated Care no excluye ni trata a las personas de manera menos favorable por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género.

- Modificaciones razonables y ayudas y servicios auxiliares gratuitos y apropiados a personas con discapacidad para que puedan comunicarse eficazmente con nosotros, por ejemplo:
  - Intérpretes calificados de lengua de señas.
  - Información por escrito en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).

Si usted o alguien a quien ayuda tiene una condición auditiva o visual que impide la comunicación, tiene derecho a recibir ayudas y servicios auxiliares sin costo alguno y en el momento oportuno. Ambetter from Coordinated Care brinda:

- Servicios gratuitos de asistencia de idiomas a las personas cuya lengua materna no sea el inglés, por ejemplo:
  - Intérpretes calificados.
  - Información escrita en otros idiomas.

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia de idiomas, llame a Ambetter from Coordinated Care al 1-877-687-1197 (TTY 711).

Si cree que Ambetter from Coordinated Care no brindó estos servicios o discriminó de otro modo por motivos de origen racial, color, nacionalidad, edad, discapacidad, sexo, orientación sexual o identidad de género, puede presentar una queja: Ambetter from Coordinated Care, 1557 Coordinator, P.O. Box 31384, Tampa, FL 33631, 1-855-577-8234 (TTY 711), Fax 1-866-388-1769, o por correo electrónico a [SM\\_Section1557Coord@centene.com](mailto:SM_Section1557Coord@centene.com). Puede presentar una queja en persona o por correo postal, fax o correo electrónico. Ambetter from Coordinated Care está disponible si necesita ayuda para presentar una queja.

También puede presentar un reclamo sobre los derechos civiles ante estos organismos:

- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. a través del portal en línea de la oficina para ese fin, en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o por teléfono: 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). Los formularios de reclamo están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.
- La Oficina del Comisionado de Seguros del Estado de Washington a través del portal en línea de la oficina para ese fin, en <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, o por teléfono al 800-562-6900 o al 360-586-0241 (TDD). Los formularios de reclamo están disponibles en <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

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