



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/ga/2026-brochures.html> or call 1-877-687-1180 (TTY 1-877-941-9231). 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 1-877-687-1180 (TTY 1-877-941-9231) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$7,500 individual / \$15,000 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 visits, and certain prescription drugs are covered before you meet your deductible (see additional information below).	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 : \$10,000 individual / \$20,000 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 (unless balance-billing is prohibited), 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 https://ambetterhealth.com/en/ga/fi/ndadoc or call 1-877-687-1180	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 the difference between the provider's charge and what your plan pays (balance

Important Questions	Answers	Why This Matters:
	(TTY 1-877-941-9231) for a list of network providers .	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	\$50 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	Specialist visit	\$100 Copay / visit; deductible does not apply	Not covered	None
	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)	50% Coinsurance for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% 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. 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.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or	Generic drugs	Tier 1a - Preferred Generic Retail: \$25 Copay / prescription;	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail

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)	
condition More information about prescription drug coverage is available at https://ambetterhealth.com/en/ga/2026formulary		deductible does not apply Tier 1b - Generic Retail: \$25 Copay / prescription; deductible does not apply		order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs	Tier 2 - Retail: \$50 Copay / prescription	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 2.5x retail cost-sharing amount.
	Non-preferred brand drugs and Non-preferred generic drugs.	Tier 3 - Retail: \$100 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
	Specialty drugs	Tier 4 - Retail: \$500 Copay / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance	None
	Emergency medical transportation	50% Coinsurance	50% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider , you may be subject to balance billing .
	Urgent care	\$75 Copay / visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$50 Copay / visit; deductible does not apply; Other Outpatient Services: 50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$50 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).
	Childbirth/delivery professional services	50% 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	50% 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).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 120 visits per year.
	Rehabilitation services	Outpatient: \$50 Copay / visit; deductible does not apply Inpatient: 50% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to a combined 40 visits per year for chiropractic care, speech therapy, physical therapy and occupational therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.

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)	
				Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: \$50 Copay / visit; deductible does not apply Inpatient: 50% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to a combined 40 visits per year for chiropractic, speech therapy, physical therapy and occupational therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered no limit.
	Skilled nursing care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	50% 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 when the life of the member is endangered) - Acupuncture - Bariatric surgery - Cosmetic surgery	- Dental care (Children) - Hearing aids - Infertility treatment - Long-term care	- Non-emergency care when traveling outside the U.S. - Private-duty nursing - Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
Chiropractic care (Limited to a combined maximum of 40 visits per year for chiropractic care, speech therapy, physical therapy and occupational therapy)	- Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.) - Routine foot care

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

- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)

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 Peach State Health [Plan](#) at 1-877-687-1180 (TTY 1-877-941-9231); Georgia Office of Insurance and Safety Fire Commissioner, 2 Martin Luther King, Jr. Drive, West Tower, Suite 702, Atlanta, Georgia, 30334, Phone: 1-800-656-2298; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Georgia Consumer Assistance Program at 1-800-656-2298; 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 [Georgia Access](#), visit <https://georgiaaccess.gov/> or call 1-888-687-1503.

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: Georgia Office of Insurance and Safety Fire Commissioner, 2 Martin Luther King, Jr. Drive, West Tower, Suite 702, Atlanta, Georgia, 30334, Phone: 1-800-656-2298. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Georgia Consumer Assistance Program at 1-800-656-2298.

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 1-877-687-1180 (TTY 1-877-941-9231).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1180 (TTY 1-877-941-9231).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-687-1180 (TTY 1-877-941-9231).

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-687-1180 (TTY 1-877-941-9231).

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	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	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*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$7,500
Copayments	\$60
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$8,820

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$4,000
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	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*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,100
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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



FROM



English:	If you, or someone you are helping, have questions about Ambetter from Peach State Health Plan, 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 1-877-687-1180 (TTY 1-877-941-9231).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Peach State Health Plan 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 1-877-687-1180 (TTY 1-877-941-9231).
Chinese:	如果您或您正在協助的對象對 Ambetter from Peach State Health Plan 所提供的任何服務有問題，且不精通英語，您有權利免費並及時以您的母語獲得幫助和資訊。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 1-877-687-1180 (TTY 1-877-941-9231)。
Yoruba:	Bí iwọ, tàbí ẹnikan tí iwọ ní ràn lówó, bá ní ibèèrè nípá Ambetter from Peach State Health Plan, tí o kò sí mọ èdè Gẹ̀ẹ̀sì sọ dádádára, o ní ètọ́ láti rí ìrànlowó àti àlàyé gbà ní èdè rẹ lófẹ́ẹ̀ àti ní àkókò tó yẹ. Bí iwọ, tàbí ẹnikan tí iwọ ní ràn lówó, bá ní ìsòro igbọ̀rọ̀ àti/tàbí ìrìran tó ní dí ibáaenisòrọ̀ lówó, o ní ètọ́ láti gba àwọn ohun ìrànlowó igbọ̀rọ̀ àti àwọn isẹ ìrànlowó láisanwó àti ní àkókò tó yẹ. Láti gba àwọn isẹ ìtumọ̀ èdè tàbí àwọn isẹ ìrànlowó, jọwọ kàn sí Àwọn isẹ Ọmọ egbẹ ní 1-877-687-1180 (TTY 1-877-941-9231).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Peach State Health Plan 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 1-877-687-1180 (TTY 1-877-941-9231).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Peach State Health Plan에 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. 통역 또는 보조 서비스를 받으시려면 1-877-687-1180 (TTY 1-877-941-9231)번으로 가입자 서비스부에 연락해 주십시오.
Hindi:	अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Peach State Health Plan से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ्त 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 1-877-687-1180 (TTY 1-877-941-9231) पर सदस्य सेवाएं से संपर्क करें.
French:	Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Peach State Health Plan 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 1-877-687-1180 (TTY 1-877-941-9231).

Amharic:	እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter from Peach State Health Plan ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቋንቋዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የአይታ ችግር ካልዎት፣ አጋዥ እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እባክዎ በ 1-877-687-1180 (TTY 1-877-941-9231) የአባል አገልግሎቶች ን ያናግሩ።
Portuguese:	Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Peach State Health Plan 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 Serviços de Membros através do número 1-877-687-1180 (TTY 1-877-941-9231).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter from Peach State Health Plan વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-877-687-1180 (TTY 1-877-941-9231) પર સભ્યની સેવાઓનો સંપર્ક કરો.
Telugu:	మీకు లేదా మీరు సహాయం చేస్తున్న వ్యక్తికి Ambetter from Peach State Health Plan గురించి ప్రశ్నలు ఉంటే మరియు మీరు ఇంగ్లీష్‌లో నిపుణులు కాకపోతే, మీకు మీ భాషలో సహాయం మరియు సహచారం సమయానుకూలంగా మరియు ఉచితంగా పొందే హక్కు ఉంది. మీకు లేదా మీరు సహాయం చేస్తున్న వ్యక్తికి వినికిడి మరియు/లేదా దృశ్య సంబంధిత శారీరక పరిస్థితి వల్ల కమ్యూనికేషన్‌లో ఆటంకం కలిగితే, మీరు సహాయక పరికరాలు మరియు సేవలను సమయానుకూలంగా మరియు ఉచితంగా పొందే హక్కు కలిగి ఉన్నారు. అనువాదం లేదా సహాయక సేవలను పొందడానికి, దయచేసి మెంబర్ సర్వీస్‌స్ ను 1-877-687-1180 (TTY 1-877-941-9231) ద్వారా సంప్రదించండి.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Peach State Health Plan، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعد 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 بخدمات الأعضاء على 1-877-687-1180 (TTY 1-877-941-9231).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Peach State Health Plan 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 1-877-687-1180 (TTY 1-877-941-9231).
Haitian Creole:	Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from Peach State Health Plan, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-877-687-1180 (TTY 1-877-941-9231).
Swahili:	Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter from Peach State Health Plan, na huelewi Kiingereza vizuri, una haki ya kupata usaidizi na maelezo kwa lugha yako bila kulipa ada yoyote na kwa wakati ufaao. Ikiwa wewe, au mtu unayemsaidia, ana tatizo la kusikia na/au la kuona ambalo linazuia mawasiliano, una haki ya kupata usaidizi na huduma za ziada bila kulipa ada yoyote na kwa wakati unaofaa. Ili kupata huduma za tafsiri au za ziada, tafadhali wasiliana na Huduma kwa Wanachama 1-877-687-1180 (TTY 1-877-941-9231).