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 <a href="https://ambetterhealth.com/en/az/2026-brochures.html">https://ambetterhealth.com/en/az/2026-brochures.html</a> or call 1-888-926-5057 (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 <a href="https://www.healthcare.gov/sbc-qlossary">https://www.healthcare.gov/sbc-qlossary</a> or call 1-888-926-5057 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,000 individual / \$10,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
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 <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.  But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For network providers: \$7,700 individual / \$15,400 family. Not applicable for out-of-network providers.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See <a href="https://ambetterhealth.com/en/az/findadoc">https://ambetterhealth.com/en/az/findadoc</a> or call 1-888-926-5057 (TTY 711) for a list of <a href="network">network</a> <a href="providers.">providers.</a>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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

	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> / visit; <u>deductible</u> 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.
If you visit a health care provider's office or clinic	Specialist visit	\$50 <u>Copay</u> / visit; <u>deductible</u> 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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 Copay / visit; deductible does not apply for laboratory & professional services  40% Coinsurance for x- ray & diagnostic imaging  40% 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)	40% 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: \$3 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

		What Yo	ou Will Pay	Limitations Evacutions 9 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
condition  More information about		deductible does not apply		order. Mail orders are subject to 2.5x retail cost-sharing amount.
prescription drug coverage is available at https://ambetterhealth.c om/en/az/2026formular		Tier 1b - Generic Retail: \$20 Copay / prescription; deductible does not apply		
У	Preferred brand drugs	Tier 2 - Retail: \$50 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
	Non-preferred brand drugs and Non-preferred generic drugs.	Tier 3 - Retail: 45% Coinsurance	Not covered	order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Specialty drugs	Tier 4 - Retail: 50% 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.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Emergency room care	40% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency medical transportation	40% Coinsurance	40% 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 <a href="network">network</a> ground/water ambulance <a href="provider">provider</a> , you may be subject to <a href="mailto:balance billing">balance billing</a> .
	Urgent care	\$50 Copay / visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Physician/surgeon fees	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 Copay / visit; deductible does not apply; Other Outpatient Services: 40% 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	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$20 <u>Copay</u> / visit; <u>deductible</u> 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 prenatal 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	40% Coinsurance	Not covered	Prior authorization may be required. Cost- sharing does not apply for preventive
	Childbirth/delivery facility services	40% Coinsurance	Not covered	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 bolo	Home health care	40% Coinsurance	Not covered	Prior authorization may be required. Limited to 42 visits per year.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: 40% Coinsurance Inpatient: 40% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 60 visits per year (combined for outpatient physical, speech, occupational, cardiac and pulmonary therapy). Note: Limits do not apply when

		What You Will Pay		Limitations Expontions & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: 40% Coinsurance Inpatient: 40% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 60 visits per year (combined for outpatient physical, speech, occupational, cardiac and pulmonary therapy). Note: Limits do not apply when treatment is provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	40% Coinsurance	Not covered	Prior authorization may be required. Limited to 90 days per year.
	Durable medical equipment	40% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	40% 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; <u>deductible</u> 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 member is endangered)
- Dental care (Children)
- Infertility treatment

Non-emergency care when traveling outside the U.S.

Acupuncture

Long-term care

Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Limited to 20 visits per year)
- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)
- Hearing aids (Limited to 1 hearing aid per ear per year)
- Private-duty nursing

- Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.)
- 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 Arizona Complete Health at 1-888-926-5057 (TTY 711); Arizona Department of Insurance, 100 N. 15th Avenue, Suite 261, Phoenix, AZ, 85007-2630, Phone: 1-602-364-2499 or 1-800-325-2548; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State Plan Program at <a href="https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/">https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit 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: Arizona Department of Insurance, 100 N. 15th Avenue, Suite 261, Phoenix, AZ, 85007-2630, Phone: 1-602-364-2499 or 1-800-325-2548.

# 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 1-888-926-5057 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-5057 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-5057 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-926-5057 (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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) coinsurance	40%

■ Hospital (facility) coinsurance

**■** Other coinsurance

# **Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a wellcontrolled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	40%

**■** Other coinsurance

40%

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

#### 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)

### 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)

#### 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	\$12,700
In this example, Peg would pay:	
Cost Sharing	
<u>Deductibles</u>	\$5,000
Copayments	\$400
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,960

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$800
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$2,500
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

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



English:	If you, or someone you're helping, have questions about Ambetter from Arizona Complete Health, 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're 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 1-888-926-5057 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Arizona Complete Health 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 1-888-926-5057 (TTY 711).
Navajo:	Daa ni, doodaii la'da ni'bineesh'a dząądi, be'esdzááh na'ídíkid 'aa Ambetter from Arizona Complete Health, dóó bineesh'a góó t'oo 'adee naash'ne di Bilagaana bizaad, ni be'esdzááh la' t'áá 'áko góó bil hánish'áásh dząądi dóó bíka'ashkíd di nihí saad gi 'ádin t'áadoo bááhilinigoo dóó di léi na'alkid lahgo 'át'éego. Dą́ą 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 1-888-926-5057 (TTY 711).
Chinese Traditional:	如果您或您正在協助的對象有關於 Ambetter from Arizona Complete Health 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得幫助和訊資訊。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 1-888-926-5057 (TTY 711)。
Chinese Simplified:	如果您或您正在帮助的人对 Ambetter from Arizona Complete Health 有疑问,并且不精通英语,您有权以免费且及时的方式获得以您所使用的语言提供的帮助和信息。如果您或您正在帮助的人有听觉和/或视觉障碍,从而导致沟通不畅,则您有权以免费且及时的方式获得辅助帮助和服务。如需获得翻译或辅助服务,请致电 1-888-926-5057 (TTY 711),联系会员服务部。
	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Arizona Complete Health

### Vietnamese:

lth 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 1-888-926-5057 (TTY 711).

# Arabic:

إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Arizona Complete Health، ولم تكن تجيد التحدث باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت تعانى، أنت أو أي شخص تساعدُه، 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 .1-888-926-5057 (TTY 711)

# Tagalog:

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Arizona Complete Health, 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 pagsasalin o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-888-926-5057 (TTY 711).

### 귀하 또는 귀하의 도움을 받는 분이 Ambetter from Arizona Complete Health에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 Korean: 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 1-888-926-5057 (TTY 711)번으로 가입자 서비스부에 연락해주십시오. Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Arizona Complete Health 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 French: 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 1-888-926-5057 (TTY 711). Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Arizona Complete Health 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 German: 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 1-888-926-5057 (TTY 711). Если у вас или у лица, которому вы помогаете, возникли какие либо вопросы о программе страхования Ambetter from Arizona Complete Health, 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 Russian: 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 1-888-926-5057 (ТТҮ 711). ご自身やあなたが介護している他の人が、Ambetter from Arizona Complete Health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 Japanese: 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、1-888-926-5057 (TTY 711)のメンバーサービスにご連絡 ください。 اگر شما یا فردی که دارید به او کمک می کنید، سؤالی دریاره Ambetter from Arizona Complete Health 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 Persian (Farsi): به رایگان و به موقع دریافت کنید. برای دریافت کمکها و خدمات امدادی لطفاً با خدمات اعضا به شماره (TTY 711) 5057-928-1 تماس بگيرىد. کے Ambetter from Arizona Complete Health جمع حققمے رغمل حمیہ، میلیز کمیہ خقم میں بانک میں اللہ کا میں اللہ کی اللہ کا میں اللہ کی الل ماہ نے کے دیر کیا ہے، کہا کہ کے ادتی ہیں کہ کا الحباہ کی کہ کہ کا کہ کا کہ کا کہ Syriac: مبقج، بنز کے عَملباہ فی حضبۃ کی مار عجعۃ کی حیدتی حنبہ کی اُفقاکی اَوجعہ کی حضبۃ کی ماروز کرتی، کی تعمته لمجمى حبك حمى ليعجعة له مرهة بخه مُهُدُّك مُتَامِمُونَه على (TTY 711) مركب عبد المحمد المحمد المحمد الم Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter from Arizona Complete Health, a ne govorite engleski jezik, imate pravo na besplatnu i blagovremenu pomoć i informacije na sopstvenom jeziku. Ako Vi, ili neko kome pomažete, imate neki poremećaj sluha i/ili vida zbog kojeg je onemogućena Serbo-Croatian: komunikacija, imate pravo da besplatno i blagovremeno dobijete pomagala i pomoćne usluge. Obratite se odeljenju za pružanje usluga članovima pozivom na broj 1-888-926-5057 (TTY 711) da biste dobili usluge prevoda ili pomoćne usluge. หากคณหรือคนที่คณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Arizona Complete Health และไม่ชำนาณในการใช้ภาษาอังกฤษ คณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมลในภาษาของคณโดย ไม่เสียค่าใช้จ่ายอย่างทันท่วงที่ หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือ Thai: การมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสีย

ค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับ

สมาชิก ที่หมายเลข 1-888-926-5057 (TTY 711)