



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://ambetter.mhsindiana.com/> or by calling 877-687-1182, TTY/TDD 800-743-3333

| Important Questions                                       | Answers                                                                                                      | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$6,800</b> individual / <b>\$13,600</b> family. Does not apply to preventive care.                       | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .                                                                                        |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                          | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                              |
| Is there an <u>out-of-pocket-limit</u> on my expenses?    | Yes, for network providers <b>\$6,800</b> individual/ <b>\$13,600</b> family. No, for non-network providers. | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.                                                                                                                                                                                                                                                          |
| What is not included in the <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, and non-network services this plan doesn't cover.                          | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| Is there an overall annual limit on what the plan pays?   | No                                                                                                           | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                                          |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="#">Find a Provider</a> or call 1-877-687-1182 for a list of participating providers.       | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?         | No, you don't need a referral to see a network specialist.                                                   | You can see the <b>specialist</b> you choose without permission from this plan; however, prior authorization is required from this plan.                                                                                                                                                                                                                                                                                                                          |
| Are there services this plan doesn't cover?               | Yes                                                                                                          | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

**Questions:** Call 877-687-1182, TTY/TDD 800-743-3333 or visit us at <http://ambetter.mhsindiana.com/>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 877-687-1182, TTY/TDD 800-743-3333 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount** you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**).
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event                                                                                                                                                       | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|-------------------------------------------------|------------------------------------------------|
| If you visit a health care <b>provider's</b> office or clinic                                                                                                              | Primary care visit to treat an injury or illness | No charge after deductible                  | Not covered                                     | -----None-----                                 |
|                                                                                                                                                                            | Specialist visit                                 | No charge after deductible                  | Not covered                                     | Prior approval required.                       |
|                                                                                                                                                                            | Other practitioner office visit                  | No charge after deductible                  | Not covered                                     | -----None-----                                 |
|                                                                                                                                                                            | Preventive care/screening/immunization           | No charge                                   | Not covered                                     | -----None-----                                 |
| If you have a test                                                                                                                                                         | Diagnostic test (x-ray, blood work)              | No charge after deductible                  | Not covered                                     | Prior approval required.                       |
|                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                     | No charge after deductible                  | Not covered                                     | Prior approval required.                       |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="#">Preferred Drug List</a> . | Generic drugs                                    | \$20 Copay                                  | Not covered                                     | -----None-----                                 |
|                                                                                                                                                                            | Preferred brand drugs                            | No charge after deductible                  | Not covered                                     | Prior approval required. Subject to deductible |
|                                                                                                                                                                            | Non-preferred brand drugs                        | No charge after deductible                  | Not covered                                     |                                                |
|                                                                                                                                                                            | Specialty drugs                                  | No charge after deductible                  | Not covered                                     |                                                |

| Common Medical Event                                                   | Services You May Need                          | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                            |
|------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| If you have outpatient surgery                                         | Facility fee (e.g., ambulatory surgery center) | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Physician/surgeon fees                         | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
| If you need immediate medical attention                                | Emergency room services                        | No charge after deductible                  | No charge after deductible                      | -----None-----                                      |
|                                                                        | Emergency medical transportation               | No charge after deductible                  | No charge after deductible                      | -----None-----                                      |
|                                                                        | Urgent care                                    | No charge after deductible                  | Not covered                                     | -----None-----                                      |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)             | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Physician/surgeon fee                          | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services   | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Mental/Behavioral health inpatient services    | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Substance use disorder outpatient services     | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Substance use disorder inpatient services      | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
| If you are pregnant                                                    | Prenatal and postnatal care                    | No charge after deductible                  | Not covered                                     | Prior approval required.                            |
|                                                                        | Delivery and all inpatient services            | No charge after deductible                  | Not covered                                     | Prior authorization required. 48 hour minimum stay. |

| Common Medical Event                                                  | Services You May Need     | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                                                          |
|-----------------------------------------------------------------------|---------------------------|---------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | No charge after deductible                  | Not covered                                     | Prior authorization required. 100 visits per benefit period.                      |
|                                                                       | Rehabilitation services   | No charge after deductible                  | Not covered                                     | Prior authorization required. 60 visits per year, 20 visits per benefit per year. |
|                                                                       | Habilitation services     | No charge after deductible                  | Not covered                                     | Prior authorization required. 60 visits per benefit period.                       |
|                                                                       | Skilled nursing care      | No charge after deductible                  | Not covered                                     | Prior authorization required. 90 days per year in a facility.                     |
|                                                                       | Durable medical equipment | No charge after deductible                  | Not covered                                     | Prior authorization required.                                                     |
|                                                                       | Hospice service           | No charge after deductible                  | Not covered                                     | Prior authorization required.                                                     |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$0 Copay/visit                             | Not covered                                     | 1 Visit per year                                                                  |
|                                                                       | Glasses                   | \$0 Copay/visit                             | Not covered                                     | 1 Item per year                                                                   |
|                                                                       | Dental check-up           | Not covered                                 | Not covered                                     | -----None-----                                                                    |

## Excluded Services & Other Covered Services

| <b>Services Your Plan Does Not Cover</b> (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)                                                                                     |                                                                                                                                                       |                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Cosmetic Surgery</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility treatment</li> <li>• Routine foot care (Not related to diabetes treatment)</li> </ul> |

| <b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) |                                                                         |                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care (Limited to 12 specialists' visits per year)</li> <li>• Routine eye care (Adult)</li> </ul>       | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing On an outpatient basis - limited to 82 visits per year)</li> </ul> |

## Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1182, TTY/TDD 800-743-3333. You may also contact your state insurance department at Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Indiana Department of Insurance, 311 West Washington Street, Suite 100, Indianapolis, IN, 46204, Phone No. (317) 232-2385 or (800) 622-4461.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1182, TTY/TDD 800-743-3333

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1182 (TDD/TTY 1-800-743-3333).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-687-1182 (TDD/TTY 1-800-743-3333).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$540
- **Patient pays** \$7,000

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$6,800        |
| Copays               | \$0            |
| Coinsurance          | \$0            |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$7,000</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,120
- **Patient pays** \$3,280

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$800          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$3,280</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✖ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✖ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✔ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✔ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## Statement of Non-Discrimination

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

Ambetter from MHS:

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

If you need these services, contact Ambetter from MHS at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you believe that Ambetter from MHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance and Appeals Coordinator, 1099 N Meridian Street, Suite 400, Indianapolis, IN 46204, 1-877-687-1182 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from MHS 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>.



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|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Spanish             | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Ambetter from MHS, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1182 (TTY/TDD 1-800-743-3333).                                                |
| Chinese             | 如果您，或是您正在協助的對象，有關於 Ambetter from MHS 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-877-687-1182 (TTY/TDD 1-800-743-3333)。                                                                                                                                                                                      |
| German              | Falls Sie oder jemand, dem Sie helfen, Fragen zum Ambetter from MHS haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1182 (TTY/TDD 1-800-743-3333) an.                            |
| Pennsylvanian Dutch | Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Ambetter from MHS, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-687-1182 (TTY/TDD 1-800-743-3333) uffrufe. |
| Burmese             | သင့်၊ မဟုတ်ကုန်၊ သို့မဟုတ် သင့်တို့က အကူအညီပေးနေသော အကူအညီရယူသူက Ambetter from MHS ၏ အကူအညီပေးနေသော အကူအညီရယူသူက မိမိတို့က အကူအညီပေးနေသော အကူအညီရယူသူက 1-877-687-1182 (TTY/TDD 1-800-743-3333) သို့မဟုတ် 1-800-743-3333 ခေါ်ဆိုပါ။                                                                       |
| Arabic              | إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Ambetter from MHS ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-877-687-1182 (TTY/TDD 1-800-743-3333).                                                                                              |
| Korean              | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from MHS 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1182 (TTY/TDD 1-800-743-3333) 로 전화하십시오.                                                                                                                         |
| Vietnamese          | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from MHS, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1182 (TTY/TDD 1-800-743-3333).                                                |
| French              | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Ambetter from MHS, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-687-1182 (TTY/TDD 1-800-743-3333).                               |

|          |                                                                                                                                                                                                                                                                        |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Japanese | ご本人様、またはお客様の身の回りの方でも、Ambetter from MHSについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合、1-877-687-1182 (TTY/TDD 1-800-743-3333)までお電話ください                                                                                                          |
| Dutch    | Als u, of iemand die u helpt, vragen heeft over Ambetter from MHS, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel 1-877-687-1182 (TTY/TDD 1-800-743-3333).                                                |
| Tagalog  | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from MHS, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1182 (TTY/TDD 1-800-743-3333). |
| Russian  | Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter from MHS, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-687-1182 (TTY/TDD 1-800-743-3333).    |
| Punjabi  | ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਸੀਂ ਜਜ਼ਮ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Ambetter from MHS ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਜਿਨ੍ਹਾਂ ਜਕਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਜਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗਿੱਲ ਕਰਨ ਲਈ, 1-877-687-1182 (TTY/TDD 1-800-743-3333) ਤੇ ਕਾਲ ਕਰੋ                    |
| Hindi    | यदि आपके, या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Ambetter from MHS के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में सुप्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषण से बात करन े के लिए, 1-877-687-1182 (TTY/TDD 1-800-743-3333) पर किँ करें। |