



Ambetter of SilverSummit Healthplan: Ambetter Secure Care 5 (2020)

Coverage for: Individual/Family | Plan Type: HMO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://ambetter.silversummithealthplan.com/2020-brochures.html>, or call 1-866-263-8134 (TTY/TDD 1-855-868-4945). 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 1-866-263-8134 (TTY/TDD 1-855-868-4945) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or \$1,250 individual / \$2,500 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 services</a> , primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your <a href="#">deductible</a> .	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> : \$5,900 individual / \$11,800 family. No, for non- <a href="#">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, and health care this <a href="#">plan</a> does not cover.	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 use a <a href="#">network provider</a> ?	Yes. See <a href="#">Find a Provider</a> or call 1-866-263-8134 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</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
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	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	No charge	\$15 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Specialist</a> visit	No charge	\$35 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	\$15 <a href="#">Copay</a> / test for laboratory outpatient & professional services ( <a href="#">deductible</a> does not apply); 20% <a href="#">Coinsurance</a> for x-ray and diagnostic imaging	Not covered	Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .

\* For more information about limitations and exceptions, see plan or policy document at <https://api.centene.com/EOC/2020/45142NV001.pdf>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> .	Generic drugs (Tier 1)	No charge	Retail: \$15 <a href="#">Copay</a> / prescription; Mail order: \$37.50 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	<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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Preferred brand drugs (Tier 2)	No charge	Retail: \$30 <a href="#">Copay</a> / prescription; Mail order: \$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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Non-preferred brand drugs (Tier 3)	No charge	30% <a href="#">Coinsurance</a>	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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Specialty drugs</a> (Tier 4)	No charge	30% <a href="#">Coinsurance</a>	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="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Physician/surgeon fees	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Emergency medical</a>	No charge	20% <a href="#">Coinsurance</a>	20%	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<a href="#">transportation</a>			<a href="#">Coinsurance</a>	<a href="#">referral</a> .
	<a href="#">Urgent care</a>	No charge	\$35 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Physician/surgeon fees	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$15 <a href="#">Copay</a> / office visit ( <a href="#">deductible</a> does not apply); 20% <a href="#">Coinsurance</a> for all other outpatient services	Not covered	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Inpatient services	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you are pregnant	Office visits	No charge	\$15 <a href="#">Copay</a> / visit; <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 services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . 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 described elsewhere in the SBC (i.e. ultrasound). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Childbirth/delivery professional services	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . 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 described elsewhere in the SBC (i.e. ultrasound). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Childbirth/delivery facility services	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . 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 described elsewhere in the SBC (i.e. ultrasound). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Unlimited benefit except for one medical social service consultation per course of treatment; one nutrition consultation by a certified registered dietitian; and health aide services are furnished only when receiving nursing services or therapy. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	60 Visits per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	60 Visits per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. 100 days per year. <a href="#">Cost sharing</a> waived at non-IHCP

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					with IHCP <a href="#">referral</a> .
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. 1 item every 3 years. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Hospice services</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. A limit of 5 days per episode applies to respite services and bereavement services. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	1 visit per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Children's glasses	No charge	No charge	Not covered	1 item per year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

\* For more information about limitations and exceptions, see plan or policy document at <https://api.centene.com/EOC/2020/45142NV001.pdf>

### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

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

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

- Bariatric surgery (One procedure per lifetime)
- Chiropractic care (20 visits per year)
- Hearing aids (Limited to a single purchase of a type of Hearing Aid, including repair & replacement, Once every (3) years)
- Infertility treatment (See policy for coverage details)
- Private-duty nursing
- Routine foot care (Related to diabetes treatment)

**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 Silver Summit Healthplan at 1-866-263-8134 (TTY/TDD 1-855-868-4945); Nevada Division of Insurance, 3300 W. Sahara Ave., Suite 275, Las Vegas, Nevada 89102 1-888-872-3234. 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 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: Nevada Division of Insurance, 3300 W. Sahara Ave., Suite 275, Las Vegas, Nevada 89102 1-888-872-3234.

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

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 1-866-263-8134, TTY/TDD 1-855-868-4945.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-263-8134, TTY/TDD 1-855-868-4945.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-263-8134, TTY/TDD 1-855-868-4945.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-263-8134, TTY/TDD 1-855-868-4945.

-----*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*-----



About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$600
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,710</b>

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$1,300
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,910</b>

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

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,650</b>

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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

### Statement of Non-Discrimination

Ambetter from SilverSummit Healthplan 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 SilverSummit Healthplan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from SilverSummit Healthplan:

- 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 SilverSummit Healthplan at 1-866-263-8134 (TTY/TDD 1-855-868-4945).

If you believe that Ambetter from SilverSummit Healthplan 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: Ambetter from SilverSummit Healthplan Appeals Unit, 2500 North Buffalo Drive, Suite 250, Las Vegas, NV 89128, 1-866-263-8134 (TTY/TDD 1-855-868-4945), Fax 1-855-742-0125. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from SilverSummit Healthplan 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>.

<b>Spanish:</b>	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de SilverSummit Healthplan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Tagalog:</b>	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from SilverSummit Healthplan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Chinese:</b>	如果您，或是您正在協助的對象，有關於 Ambetter from SilverSummit Healthplan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-866-263-8134 (TTY/TDD 1-855-868-4945)。
<b>Korean:</b>	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from SilverSummit Healthplan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-263-8134 (TTY/TDD 1-855-868-4945) 로 전화하십시오.
<b>Vietnamese :</b>	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from SilverSummit Healthplan, 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 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Amharic:</b>	እርስዎ ወይም እርስዎ የሚርዳችሁ ሰው ስለ Ambetter from SilverSummit Healthplan ግብር ጥያቄ ካለዎት ያለምንም ወጪ በጥንቃቄ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት። ለስተርጓሚ ለማግኘት በ 1-866-263-8134 (TTY/TDD 1-855-868-4945) ይደውሉ።
<b>Thai:</b>	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้ไม่มีคำถามเกี่ยวกับ Ambetter from SilverSummit Healthplan ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Japanese:</b>	Ambetter from SilverSummit Healthplan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-263-8134 (TTY/TDD 1-855-868-4945) までお電話ください。
<b>Arabic:</b>	بـ اـتـ صلـمـ تـرـجـمـ معـ لـ تـحـثـ بـ كـلـ قـةـ أـبـةـ دـونـ مـنـ بـ لـغـتـكـ الـ ضـرـورـيةـ وـالـمـعـلـومـاتـ الـمـسـاعـدةـ عـلىـ الـحـصـولـ فـيـ الـحـقـ لـدـونـكـ ، Ambetter from SilverSummit Healthplan حـولـ أـمـةـ ذـلـكـ مـسـاعـدـةـ شـخـصـ لـدىـ أوـ لـدـونـكـ كـانـ ذـا 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Russian :</b>	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from SilverSummit Healthplan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>French :</b>	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from SilverSummit Healthplan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>Persian:</b>	کـ رـدنـ صـدـ بـتـ بـ رـايـ کـ نـيـدـ تـرـجـمـ وـ تـ خـودـ زـ بـانـ بـ يـهـ رـايـ وـ گـانـ بـ صـورـتـ رـاـ اـطـلـاعـتـ وـ کـ مـکـ کـهـ بـ رـخـورـدـ اـزـ بـهـ حـقـ اـونـ اـزـ دـارـيد، Ambetter from SilverSummit Healthplan مـوردـ درـ سـؤـالـيـ کـ نـيـدـ مـيـ کـ مـکـ اـوـ بـهـ کـهـ کـ سـيـ يـاـ شـما، اـگـر بـ يـگـ يـرـودـ تـ مـاسـ 1-866-263-8134 (TTY/TDD 1-855-868-4945) شـمارهـ بـاـ مـ تـرـجـمـ بـا
<b>Samoan :</b>	'Āfai e iai ni au fesili, po'o ni fesili fo'i a se isi 'o 'e fesoasoani i ai, e uiga i le Ambetter from SilverSummit Healthplan, e iai lau āiā e sa'ili ai ni fa'amatalaga i lau lava gagana e aunoa ma se tofogi. 'A 'e fia talanoa i se fa'amatala'upu, telefoni le 1-866-263-8134 (TTY/TDD 1-855-868-4945).
<b>German:</b>	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from SilverSummit Healthplan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-263-8134 (TTY/TDD 1-855-868-4945) an.
<b>Ilocano:</b>	No dakayo, wenna ti tultulunganyo, ket addaan iti saludod maipapan ti Ambetter from SilverSummit Healthplan, addaankayo iti karbengan nga agpatulong ken dumawat iti impormasyon a naiyulog iti lengguaheyo nga awanan ti bayad. Tapno makasaritay iti tao a mangiyulog iti sabali nga lengguahe, umawag iti 1-866-263-8134 (TTY/TDD 1-855-868-4945).