



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.arhealthwellness.com/2020-brochures.html>, or call 1-877-617-0390, (TTY/TDD 1-877-617-0392). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-877-617-0390, (TTY/TDD 1-877-617-0392) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or Network providers : \$6,200 individual / \$12,400 family. Non- network providers : \$12,400 individual / \$24,800 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care services , primary care, specialist and urgent care office visits, children's eye exam and glasses, imaging, diagnostic tests , generic and preferred brand drugs are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, \$1,000 individual / \$2,000 family for prescription drug coverage . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For network providers : \$7,200 individual / \$14,400 family. For non- network providers : \$14,400 individual / \$28,800 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See Find a Provider or call 1-877-617-0390 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

		billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$50 Copay / visit; deductible does not apply	50% Coinsurance ; deductible does not apply	Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$75 Copay / visit; deductible does not apply	50% Coinsurance ; deductible does not apply	Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening/immunization	No charge	No charge	50% Coinsurance ; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Cost sharing waived at non-IHCP with IHCP referral .
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$50 Copay / test; deductible does not apply	50% Coinsurance ; deductible does not apply	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. Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET scans, MRIs)	No charge	\$150 Copay / test; deductible does not apply	50% Coinsurance ; deductible does not apply	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List .	Generic drugs (Tier 1)	No charge	Retail: \$10 Copay / prescription; Mail Order: \$25 Copay / prescription; deductible does not apply	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Preferred brand drugs (Tier 2)	No charge	Retail: \$50 Copay / prescription; Mail Order: \$125 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 order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred brand drugs (Tier 3)	No charge	Retail: \$100 Copay / prescription; Mail Order: \$250 Copay / prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. \$1,000 individual / \$2,000 family Rx drug deductible for non-preferred brand and specialty drugs . Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Specialty drugs (Tier 4)	No charge	Retail: \$250 Copay / prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. \$1,000 individual / \$2,000 family Rx drug deductible for non-preferred brand and specialty drugs . Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. Cost sharing waived at non-IHCP with IHCP referral .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you need immediate	Emergency room care	No charge	\$250 Copay / visit	\$250 Copay /	Cost sharing waived at non-IHCP with IHCP

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		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)	
medical attention				visit	referral .
	Emergency medical transportation	No charge	20% Coinsurance	20% Coinsurance	Cost sharing waived at non-IHCP with IHCP referral .
	Urgent care	No charge	\$60 Copay / visit; deductible does not apply	50% Coinsurance ; deductible does not apply	Cost sharing waived at non-IHCP with IHCP referral .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$1,000 Copay per day	50% Coinsurance	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	No charge after deductible	50% Coinsurance	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$50 Copay / office visit (deductible does not apply); No charge for all other outpatient services	50% Coinsurance ; deductible does not apply	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization). Cost sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No charge	\$1,000 Copay per day	50% Coinsurance	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	\$50 Copay / visit, deductible does not apply	50% Coinsurance ; deductible does not apply	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 . 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). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	No charge after deductible	50% Coinsurance	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 . Depending on the type of

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)	
					services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery facility services	No charge	\$1,000 Copay per day	50% Coinsurance	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 . 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). Cost sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	50% Coinsurance	Prior authorization may be required. 50 Visits per year. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	\$50 Copay / visit; deductible does not apply	50% Coinsurance ; deductible does not apply	Combined 30 visit limit per year for PT, OT, ST and chiropractic care. Cost sharing waived at non-IHCP with IHCP referral .
	Habilitation services	No charge	\$50 Copay / visit; deductible does not apply	50% Coinsurance ; deductible does not apply	30 Visits per year for outpatient habilitative services. 180 visits per year for developmental services. Cost sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No charge	\$100 Copay per day	50% Coinsurance	Prior authorization may be required. 60 days per year in a facility. Cost sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No charge	\$50 Copay / item; deductible does not apply	50% Coinsurance ; deductible does not apply	Prior authorization may be required. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	20% Coinsurance	50%	Prior authorization may be required. Benefits for

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)	
				Coinsurance	hospice inpatient, home or outpatient care are available to a terminally ill covered person for one continuous period up to 180 days in a covered person's lifetime. Cost sharing waived at non-IHCP with IHCP referral .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	1 visit per year. Out-of-network provider eye exam covered up to \$38.50. Cost sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No charge	No charge	No charge	1 item per year. Out-of-network provider frames or contacts covered up to \$50, see schedule for lens limit. Cost sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	Not covered	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](#).)

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| <ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Cosmetic surgery • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|--|
| <ul style="list-style-type: none"> • Chiropractic care (Limited to 30 specialist visits per year combined with speech, physical and occupational therapy) • Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year.) | <ul style="list-style-type: none"> • Hearing aids (Limited to one pair every three years) • Infertility treatment (See policy for coverage details) | <ul style="list-style-type: none"> • Routine eye care (Adult-one visit & one item per year. Dollar limits apply.) • Routine foot care (For 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 Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392); Arkansas Insurance Department, 1200 West Third Street Little Rock, AR 72201-1904, Phone No. (501) 371-2600 or 1-800-282-9134 Fax No. (501) 371-2618 Seniors No. (800) 224-6330. 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 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: Arkansas Insurance Department, 1200 West Third Street Little Rock, AR 72201-1904, Phone No. (501) 371-2600 or 1-800-282-9134 Fax No. (501) 371-2618 Seniors No. (800) 224-6330. Additionally, a consumer assistance program can help you file your appeal. Contact 1-855-332-2227 or 1-501-371-2645.

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 1-877-617-0390, (TTY/TDD 1-877-617-0392).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-617-0390, (TTY/TDD 1-877-617-0392).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-617-0390, (TTY/TDD 1-877-617-0392).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-617-0390, (TTY/TDD 1-877-617-0392).

-----*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	\$6,200
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$1,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,600
Copayments	\$2,600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,260

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$6,200
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$1,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

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

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$4,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,060

Mia's Simple Fracture

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

■ The plan's overall deductible	\$6,200
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$1,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$500
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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 Arkansas Health & Wellness 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 Arkansas Health & Wellness does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Arkansas Health & Wellness:

- 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 Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392).

If you believe that Ambetter from Arkansas Health & Wellness 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 Arkansas Health & Wellness Appeals Unit, P.O. Box 25538, Little Rock, AR 72221, 1-877-617-0390 (TTY/TDD 1-877-617-0392), Fax 1-866-811-3255. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Arkansas Health & Wellness 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>.



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Arkansas Health & Wellness, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Arkansas Health & Wellness, 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 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Marshallese:	Ñe kwe, ak bar juon eo kwōj jipañe, ewōr an kajitōk kōn Ambetter from Arkansas Health & Wellness, ewōr am jimwe in bōk jipañ im melele ko ilo kajin eo am ejjelōk wōñāān. Ñan kōnono ippān juon ri-ukōk, kirōk 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Arkansas Health & Wellness 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 1-877-617-0390 (TTY/TDD 1-877-617-0392)。
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Arkansas Health & Wellness, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Arkansas Health & Wellness, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Arkansas Health & Wellness، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-617-0390 (TTY/TDD 1-877-617-0392).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Arkansas Health & Wellness 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 1-877-617-0390 (TTY/TDD 1-877-617-0392) an.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Arkansas Health & Wellness, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter from Arkansas Health & Wellness, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Arkansas Health & Wellness 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-617-0390 (TTY/TDD 1-877-617-0392) 로 전화하십시오.
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Arkansas Health & Wellness, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Japanese:	Ambetter from Arkansas Health & Wellness 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、1-877-617-0390 (TTY/TDD 1-877-617-0392) までお電話ください。
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Arkansas Health & Wellness के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुआषिये से बात करने के लिए 1-877-617-0390 (TTY/TDD 1-877-617-0392) पर कॉल करें।
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Arkansas Health & Wellness વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-617-0390 (TTY/TDD 1-877-617-0392) ઉપર કોલ કરો.