



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.AbsoluteTotalCare.com/2020-brochures.html>, or call 1-833-270-5443 (Relay 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-833-270-5443 (Relay 711) 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> doesn't 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 1-833-270-5443 (Relay 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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> .
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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> .

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> .

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="#">Emergency medical transportation</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="#">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> after <a href="#">deductible</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</a>

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="#">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 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. 60 Visits per year. <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	30 Visits per year per therapy (PT, OT, ST). <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	Prior authorization may be required. No visit limit applies. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .

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="#">Skilled nursing care</a>	No charge	20% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. 60 Days per year. <a href="#">Cost sharing</a> waived at non-IHCP 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. <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. 6 months per episode. <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-----

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<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>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Dental care (Adult-visit &amp; item limits apply per year. \$1,000 annual dollar limit per year.)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult-one visit &amp; one item per year. Dollar limits apply.)</li> <li>Routine foot care (For diabetes treatment)</li> </ul>	

**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 Absolute Total Care at 1-833-270-5443 (Relay 711); South Carolina Department of Insurance, PO Box 100105, Columbia, SC 29202, Phone No. (803) 737-6180 or (800) 768-3467. 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: South Carolina Department of Insurance, PO Box 100105, Columbia, SC 29202, Phone No. (803) 737-6180 or (800) 768-3467.

**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 1-833-270-5443 (Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-270-5443 (Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-270-5443 (Relay 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-270-5443 (Relay 711).

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



## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

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 Absolute Total Care 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 Absolute Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Absolute Total Care:

- 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 Absolute Total Care at 1-833-270-5443 (Relay 711).

If you believe that Ambetter from Absolute Total Care 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 Absolute Total Care, ATTN: Ambetter Grievances and Appeals Department, 12515-8 Research Blvd, Suite 400, Austin, TX 78759, 1-833-270-5443 (Relay 711), Fax: 1-833-886-7956. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Absolute Total Care 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 from Absolute Total Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-270-5443 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Absolute Total Care,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-270-5443 (Relay 711) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos Ambetter from Absolute Total Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-270-5443 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from Absolute Total Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-270-5443 (Relay 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Absolute Total Care, вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-270-5443 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711) an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Absolute Total Care, વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-270-5443 (Relay 711) ઉપર કોલ કરો.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول ،Ambetter from Absolute Total Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-270-5443 (Relay 711).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Absolute Total Care, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-833-270-5443 (Relay 711).
Japanese:	Ambetter from Absolute Total Care, 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、1-833-270-5443 (Relay 711). までお電話ください。
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Absolute Total Care ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-833-270-5443 (Relay 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Absolute Total Care, के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-270-5443 (Relay 711) पर कॉल करें।
Mon-Khmer, Cambodian:	ប្រសិនបើអ្នកឬ ម្ចាស់មនុស្សដែលអ្នកកំពុងជួយមានបញ្ហាអំពី Ambetter from Absolute Total Care អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសាខ្មែរដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅ លេខ 1-833-270-5443 (Relay 711) ។