



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.homestatehealth.com/2020-brochures.html> or call 1-855-650-3789 (TTY/TDD 1-877-250-6113). 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) 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 \$5,400 individual / \$10,800 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> , children's eye exam and glasses 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> : \$6,750 individual / \$13,500 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 1-855-650-3789 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> .  |



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   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|   | <a href="#">Specialist</a> visit                       | No charge   | 30% <a href="#">Coinsurance</a>      | 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   | 30% <a href="#">Coinsurance</a>      | 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   | 30% <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 drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> . | Generic drugs (Tier 1)                                 | No charge   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | <a href="#">Prescription drugs</a> are provided up to 34 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   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 34 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   | 40% <a href="#">Coinsurance</a>      | Not covered                                     | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 34 days retail and up to 90 days through mail order. Mail   |

\*For more information about limitations and exceptions, see plan or policy document at <https://api.centene.com/EOC/2020/99723MO009.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) |  |
|   |  |   |                                      |   | 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   | 40% <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> .                                 |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | No charge   | 30% <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   | 30% <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 immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge   | 30% <a href="#">Coinsurance</a>      | 30% <a href="#">Coinsurance</a>                 | <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|   | <a href="#">Emergency medical transportation</a> | No charge   | 30% <a href="#">Coinsurance</a>      | 30% <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   | 30% <a href="#">Coinsurance</a>      | 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   | 30% <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   | 30% <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   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization). Two mental health assessments per year are covered Out-of-Network. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|   | Inpatient services                               | No charge   | 30% <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   | 30% <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  |

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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) |  |
|  |   |   |                                      |   | 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   | 30% <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   | 30% <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   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | Prior authorization may be required. 100 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   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | 20 Visits per therapy per year for OT and PT. (Limits do not apply to autism services or speech therapy). <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/2020/99723MO009.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) |   |
|  | <a href="#">Habilitation services</a>     | No charge   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | 20 visits per therapy per year. (Limits do not apply to autism services or speech therapy). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .    |
|  | <a href="#">Skilled nursing care</a>      | No charge   | 30% <a href="#">Coinsurance</a>      | Not covered                                     | Prior authorization may be required. 150 Days per year combined with inpatient rehabilitation. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|  | <a href="#">Durable medical equipment</a> | No charge   | 30% <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   | 30% <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 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/2020/99723MO009.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
- Bariatric surgery
- 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.)

- Chiropractic care (26 visits per year. Visits in excess of 26 require prior authorization)
- Hearing aids (One pair per year. Covered for all ages)
- Infertility treatment (Diagnosis only)
- Private-duty nursing (Prior authorization required, limited to 82 visits per year)
- 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 Home State Health at 1-855-650-3789 (TTY/TDD 1-877-250-6113); Missouri Department of Insurance, PO Box 690, Jefferson City, MO 65102-0690, Phone No. (573) 751-4126. 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: Missouri Department of Insurance, PO Box 690, Jefferson City, MO 65102-0690, Phone No. (573) 751-4126. Additionally, a consumer assistance program can help you file your appeal. Contact 800-726-7390.

**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 1-855-650-3789 (TTY/TDD 1-877-250-6113).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-650-3789 (TTY/TDD 1-877-250-6113).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-650-3789 (TTY/TDD 1-877-250-6113).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-650-3789 (TTY/TDD 1-877-250-6113).

-----*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> | \$5,400 |
| ■ <a href="#">Specialist coinsurance</a>                        | 30%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$3,000 |
| Copayments                 | \$0     |
| Coinsurance                | \$3,700 |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$6,760 |

### 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> | \$5,400 |
| ■ <a href="#">Specialist coinsurance</a>                        | 30%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$4,650 |
| Copayments                 | \$0     |
| Coinsurance                | \$2,090 |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Joe would pay is | \$6,800 |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$5,400 |
| ■ <a href="#">Specialist coinsurance</a>                        | 30%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$1,300 |
| Copayments                 | \$0     |
| Coinsurance                | \$600   |
| 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 Home State Health 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 Home State Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Home State Health:

- 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 Home State Health at 1-855-650-3789 (TTY/TDD 1-877-250-6113).

If you believe that Ambetter from Home State Health 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/Appeals Home State Health, 16090 Swingley Ridge Road, Suite 500, Chesterfield, MO 63017, 1-855-650-3789 (TTY/TDD 1-877-250-6113), Fax, 1-855-805-9812. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Home State Health 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 Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).  |
| <b>Chinese:</b>            | 如果您，或是您正在協助的對象，有關於 Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113)。  |
| <b>Vietnamese:</b>         | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State Health, 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 1-855-650-3789 (TTY/TDD 1-877-250-6113).  |
| <b>Serbo-Croatian:</b>     | Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).  |
| <b>German:</b>             | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.                                   |
| <b>Arabic:</b>             | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).   |
| <b>Korean:</b>             | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113) 로 전화하십시오.   |
| <b>Russian:</b>            | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113). |
| <b>French:</b>             | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).                                      |
| <b>Tagalog:</b>            | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Home State Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-650-3789 (TTY/TDD 1-877-250-6113).                                     |
| <b>Pennsylvania Dutch:</b> | Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kaw! 1-855-650-3789 (TTY/TDD 1-877-250-6113).                                      |
| <b>Persian:</b>            | اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Home State Health دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگیرید.   |
| <b>Cushite:</b>            | Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajjin dubadhuu, 1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).   |
| <b>Portuguese:</b>         | Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).  |
| <b>Amharic:</b>            | አርሰዎ ወይም አርሰዎ የሚርዱት ሰው ስለ Ambetter from Home State Health ጥያቄ ካለዎት ያለምንም ወጪ በጳጳሪዎ ድጋፍ አንዲሁም መረጃ የማግኘት መብት አለዎት፤ ፡ አስተርጓሚ ለማግኘት በ 1-855-650-3789 (TTY/TDD 1-877-250-6113) ይደውሉ፤   |