



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/2021-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> ?                                | \$250 individual / \$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</a> services, primary care 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> : \$2,700 individual / \$5,400 family. Not applicable for <a href="#">out-of-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 1-866-263-8134 (TTY/TDD 1-855-868-4945) 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                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                 |                                                         | Network Provider<br>(You will pay the least)                                                                                                                                                       | Out-of-Network Provider<br>(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        | \$5 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                       | Not covered                                        | Virtual Visits from Ambetter Health covered at \$0, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.                                                                                   |
|                                                                                                                                                                                 | <a href="#">Specialist</a> visit                        | 35% <a href="#">Coinsurance</a>                                                                                                                                                                    | Not covered                                        | ----None----                                                                                                                                                                                                                |
|                                                                                                                                                                                 | <a href="#">Preventive care/screening</a> /immunization | No charge; <a href="#">deductible</a> does not apply                                                                                                                                               | 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.                                   |
| If you have a test                                                                                                                                                              | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$20 <a href="#">Copay</a> / test for laboratory outpatient & professional services ( <a href="#">deductible</a> does not apply); 35% <a href="#">Coinsurance</a> for x-ray and diagnostic imaging | Not covered                                        | Prior authorization may be required. Covered No Limit. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details.       |
|                                                                                                                                                                                 | Imaging (CT/PET scans, MRIs)                            | 35% <a href="#">Coinsurance</a>                                                                                                                                                                    | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                      |
| 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)                                  | Retail: \$5 <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.                                      |
|                                                                                                                                                                                 | Preferred brand drugs (Tier 2)                          | Retail: \$50 <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. |
|                                                                                                                                                                                 | Non-preferred brand drugs (Tier 3)                      | Retail: 50% <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="#">Specialty drugs</a> (Tier 4)                | Retail: 50% <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.                                                                             |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 35% <a href="#">Coinsurance</a>                                                                                                                                | 35% <a href="#">Coinsurance</a>                    | -----None-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Emergency medical transportation</a> | 35% <a href="#">Coinsurance</a>                                                                                                                                | 35% <a href="#">Coinsurance</a>                    | -----None-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Urgent care</a>                      | \$10 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                  | Not covered                                        | -----None-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 15% <a href="#">Coinsurance</a> / Office Visit ( <a href="#">deductible</a> does not apply); 35% <a href="#">Coinsurance</a> for all other outpatient services | Not covered                                        | Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | Inpatient services                               | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you are pregnant                                                       | Office visits                                    | \$5 <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> , such as routine pre-natal and post-natal screenings. 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). |
|                                                                           | Childbirth/delivery professional services        | 35% <a href="#">Coinsurance</a>                                                                                                                                | Not covered                                        | Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> .                                                                                                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                              |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                     |
|                                                                | Childbirth/delivery facility services     | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Unlimited except for the following: limited to 1 medical social service consultation per course of treatment and 1 nutrition consultation.                                                     |
|                                                                | <a href="#">Rehabilitation services</a>   | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Inpatient and Outpatient <a href="#">Rehabilitation Services</a> are limited to a combined 120 visits per year.                                                                                |
|                                                                | <a href="#">Habilitation services</a>     | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Inpatient and Outpatient <a href="#">Habilitation Services</a> are limited to a combined 120 visits per year.                                                                                  |
|                                                                | <a href="#">Skilled nursing care</a>      | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Limited to 100 days per year.                                                                                                                                                                  |
|                                                                | <a href="#">Durable medical equipment</a> | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Purchased items are limited to 1 every 3 years.                                                                                                                                                |
|                                                                | <a href="#">Hospice services</a>          | 35% <a href="#">Coinsurance</a>                      | Not covered                                        | Prior authorization may be required. Covered No Limit. Respite care is limited to 5 days/visits per 90 days of home hospice and bereavement services are limited to 5 group therapy sessions per episode.                           |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | Limited to 1 visit per year.                                                                                                                                                                                                        |
|                                                                | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply | Not covered                                        | Limited to 1 item per year.                                                                                                                                                                                                         |
|                                                                | Children's dental check-up                | 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](#).)**

- 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 (Limited to 1 procedure per lifetime.)
- Chiropractic care (Limited to 20 visits per year.)
- Hearing aids (Limited to 1 item every 3 years.)
- Infertility treatment (Artificial insemination services are limited to 6 cycles per lifetime.)
- Private-duty nursing
- Routine foot care (Coverage is limited to diabetes care only.)

**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 SilverSummit 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.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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

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 | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,710</b> |

### 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> | \$250 |
| ■ <a href="#">Specialist coinsurance</a>                        | 35%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%   |
| ■ Other <a href="#">coinsurance</a>                             | 35%   |

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 | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$300          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,470</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$250 |
| ■ <a href="#">Specialist coinsurance</a>                        | 35%   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 35%   |
| ■ Other <a href="#">coinsurance</a>                             | 35%   |

This EXAMPLE event includes services like:

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

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$900          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,160</b> |



|                     |                                                                                                                                                                                                                                                                                                                                                       |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 tinutulungan, 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 ግብ ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ ፡ እስተርጓሚ ለማግኘት በ 1-866-263-8134 (TTY/TDD 1-855-868-4945) ይደውሉ፤                                                                                                                                                              |
| <b>Thai:</b>        | หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from SilverSummit Healthplan ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน 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>      | ب - انا ص لم ترجم مع ل ل تحدث. ب لة كة أوة دون من ب لة لك ال ضرورية والمة لومات المساعدة على الحصول في الحق ل دونك ، Ambetter from SilverSummit Healthplan حول أمة لة تة ساعدة شخص ل دي أو ل دونك كان ذا 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>     | ب - گ یرو د ت مش 1-866-263-8134 (TTY/TDD 1-855-868-4945) شماره ب ا م ترجم ب ا ک ر دن ص د ب ت ب رای ک ن د یرو ی ت خ و د ز ی ان ب ی رای گ ن ب ص و ر ت را ا ط ل ا ع ت و ک م ک ب ب ر خ و ر د ا ی و د ح ق ا و ن ا ز د ا ر د ب ، Ambetter from SilverSummit Healthplan م و ر د ن ر م و ا ل ی ک ن د ی م ی ک م ک ا و ب ی ک م ک م ی ب ا ش ا ، ا گ ر            |
| <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 totogi. ‘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 saludsod maipapan ti Ambetter from SilverSummit Healthplan, addaankayo iti karbengan nga agpatulong ken dumawat iti impormasyon a naiyulog iti lengguaheyo nga awanan ti bayad. Tapno makasarita iti tao a mangiyulog iti sabali nga lengguahe, umawag iti 1-866-263-8134 (TTY/TDD 1-855-868-4945). |

### 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>.