



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://ambetterofnorthcarolina.com/2022-brochures.html>, or call 1-833-863-1310 (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 1-833-863-1310 (Relay 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,500 individual / \$3,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services, primary care, <u>specialist</u> , and <u>urgent care</u> office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes, \$3,800 individual / \$7,600 family for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$8,700 individual / \$17,400 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://ambetterofnorthcarolina.com/findadoc">https://ambetterofnorthcarolina.com/findadoc</a> or call 1-833-863-	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be

	1310 (Relay 711) for a list of <a href="#">network providers</a> .	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 (You will pay the least)	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	\$40 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$125 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Covered No Limit.
	<a href="#">Preventive care/screening/immunization</a>	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)	\$60 <a href="#">Copay</a> / test; <a href="#">deductible</a> does not apply for laboratory & professional services  50% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging  50% <a href="#">Coinsurance</a> for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.  Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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="https://ambetterofnorthcarolina.com/2022formulary">prescription drug coverage</a> is available at <a href="https://ambetterofnorthcarolina.com/2022formulary">https://ambetterofnorthcarolina.com/2022formulary</a> .	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply  Generic Retail: \$35 <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.
	Preferred brand drugs (Tier 2)	Retail: \$195 <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: \$250 <a href="#">Copay</a> / prescription; subject to Rx drug <a href="#">deductible</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. \$3,800 individual / \$7,600 family Rx drug <a href="#">deductible</a> for non-preferred brand and <a href="#">specialty drugs</a> .
	<a href="#">Specialty drugs</a> (Tier 4)	Retail: 50% <a href="#">Coinsurance</a> ; subject to Rx drug <a href="#">deductible</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. \$3,800 individual / \$7,600 family Rx drug <a href="#">deductible</a> for non-preferred brand and <a href="#">specialty drugs</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$2,500 <a href="#">Copay</a> / visit (\$1,250 <a href="#">Copay</a> / visit for facility; \$1,250 <a href="#">Copay</a> / visit for physician fee)	\$2,500 <a href="#">Copay</a> / visit (\$1,250 <a href="#">Copay</a> / visit for facility; \$1,250 <a href="#">Copay</a> / visit for physician fee)	Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	50% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	<a href="#">Urgent care</a>	\$60 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Covered No Limit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$3,000 <a href="#">Copay</a> per Day	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Covered No Limit.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 <a href="#">Copay</a> /Office Visit ( <a href="#">deductible</a> does not apply); 50% <a href="#">Coinsurance</a> for 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	\$3,000 <a href="#">Copay</a> per Day	Not covered	Prior authorization may be required. Covered No Limit.
<b>If you are pregnant</b>	Office visits	\$40 <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 <a href="#">screenings</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).
	Childbirth/delivery professional services	No charge; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . 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
	Childbirth/delivery facility services	\$3,000 <a href="#">Copay</a> per Day	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				services described elsewhere in the SBC (i.e. ultrasound).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	<a href="#">Rehabilitation services</a>	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Limited to 30 visits per year for outpatient speech therapy; limited to a combined 30 visits per year for outpatient occupational therapy, physical therapy and chiropractic care. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	<a href="#">Habilitation services</a>	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Limited to 30 visits per year for outpatient speech therapy; limited to a combined 30 visits per year for outpatient occupational therapy, physical therapy and chiropractic care. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis.
	<a href="#">Skilled nursing care</a>	\$3,000 <a href="#">Copay</a> per Day	Not covered	Prior authorization may be required. Limited to 60 days per year.
	<a href="#">Durable medical equipment</a>	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	<a href="#">Hospice services</a>	50% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 exam 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 (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- 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 ([Medically necessary](#) for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity.)
- Chiropractic care (Limited to a combined 30 visits per year for outpatient occupational therapy, physical therapy and chiropractic care.)
- Hearing aids (Limited to 1 hearing aid per hearing impaired ear, and replacement hearing aids, once every 36 months.)
- Infertility treatment (Includes certain services related to: diagnosis, correction of underlying medical conditions that cause infertility and treatment. Note: a lifetime benefit limit applies, per member, of three medical ovulation induction cycles.)
- Private-duty nursing
- Routine foot care (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 of North Carolina Inc. at 1-833-863-1310 (Relay 711); North Carolina Department of Insurance, 1201 Mail Service Center Raleigh, NC 27699-1201, Phone No. 1-800-546-5664 or 1-919-807-6750. 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: North Carolina Department of Insurance, 1201 Mail Service Center Raleigh, NC 27699-1201, Phone No. 1-800-546-5664 or 1-919-807-6750. Additionally, a consumer assistance program can help you file your appeal. Contact 877-885-0231.

### 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 1-833-863-1310 (Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-863-1310 (Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-863-1310 (Relay 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-863-1310 (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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$125
■ Hospital (facility) <a href="#">copayment</a>	\$3,000
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$3,600
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$5,160</b>
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### 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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$125
■ Hospital (facility) <a href="#">copayment</a>	\$3,000
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$4,300
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$5,020</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$125
■ Hospital (facility) <a href="#">copayment</a>	\$3,000
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$400

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,500</b>
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\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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



<b>Spanish:</b>	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of North Carolina Inc., tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-863-1310 (Relay 711).
<b>Chinese:</b>	如果您，或是您正在協助的對象，有關於 Ambetter of North Carolina Inc.，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 1-833-863-1310 (Relay 711)。
<b>Vietnamese:</b>	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of North Carolina Inc., 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 1-833-863-1310 (Relay 711).
<b>Korean:</b>	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of North Carolina Inc.,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-863-1310 (Relay 711). 로 전화하십시오.
<b>French:</b>	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of North Carolina Inc., vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-863-1310 (Relay 711).
<b>Arabic:</b>	إذا كان لديك أو لدى شخص تساعد أسئلة حول ، Ambetter of North Carolina Inc. ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل 1-833-863-1310 (Relay 711).
<b>Hmong:</b>	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter of North Carolina Inc., koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-833-863-1310 (Relay 711).
<b>Russian:</b>	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of North Carolina Inc., вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-863-1310 (Relay 711).
<b>Tagalog:</b>	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of North Carolina Inc., may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-863-1310 (Relay 711).
<b>Gujarati:</b>	જે તમને અથવા તમે જેમની મદદ કરી રહો છો તેમને, Ambetter of North Carolina Inc., વિશે કોઈ પરસ્પર હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પરાસ્પર કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-863-1310 (Relay 711) ઉપર કોલ કરો.
<b>Mon-Khmer, Cambodian:</b>	បសិនេលាកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានបញ្ហាអំពី Ambetter of North Carolina Inc., អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសា លាភអ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែលេខ 1-833-863-1310 (Relay 711)។
<b>German:</b>	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of North Carolina Inc., 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 1-833-863-1310 (Relay 711) an.
<b>Hindi:</b>	आप या जिसकी आप मदद कर रहे हैं उनके Ambetter of North Carolina Inc., के बारे में कोई सवाल हों, तो आपको बिना किसी खचरके अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-863-1310 (Relay 711) पर कॉल करें।
<b>Laotian:</b>	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມ ກ່ຽວກັບ Ambetter of North Carolina Inc., ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະໄດ້ກັບນາຍພາສາໃຫ້ໂທຫາ 1-833-863-1310 (Relay 711).
<b>Japanese:</b>	Ambetter of North Carolina Inc., 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、1-833-863-1310 (Relay 711). までお電話ください。

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- 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)
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  - Qualified interpreters
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If you need these services, contact Ambetter of North Carolina Inc., at 1-833-863-1310 (Relay 711).

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