



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://ambetteroftennessee.com/2024-brochures.html>, or call 1-833-709-4735 (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 1-833-709-4735 (Relay 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$700 individual / \$1,400 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$3,000 individual / \$6,000 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, penalties for failure to obtain <u>preauthorization</u> for services, 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 https://ambetteroftennessee.com/findadoc or call 1-833-709-4735 (Relay 711) for a list of <u>network providers</u> .	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 aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	Specialist visit	\$40 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance for laboratory & professional services 30% Coinsurance for x-ray & diagnostic imaging 30% Coinsurance 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.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$10 Copay / prescription; deductible does not apply Generic Retail: \$10 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount.

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)	
More information about prescription drug coverage is available at https://ambetteroftennessee.com/2024formulary .	Preferred brand drugs (Tier 2)	Retail: \$20 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
	Non-preferred brand and non-preferred generic drugs (Tier 3)	Retail: \$60 Copay / prescription	Not covered	
	Specialty drugs (Tier 4)	Retail: \$250 Copay / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	30% Coinsurance	30% Coinsurance	Covered No Limit.
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider , you may be subject to balance billing .
	Urgent care	\$30 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 Copay / visit; deductible does not apply; Other Outpatient Services: 30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	30% Coinsurance	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)	
If you are pregnant	Office visits	\$20 Copay / visit; deductible 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. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% Coinsurance	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	30% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 visits per year.
	Rehabilitation services	Outpatient: \$20 Copay / visit; deductible does not apply Inpatient: 30% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech therapy); limited to 36 visits per year per therapy for cardiac and pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: \$20 Copay / visit; deductible does not apply Inpatient: 30% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech therapy); limited to 36 visits per year per therapy for cardiac and pulmonary therapy. Note: Limits do not apply

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)	
				when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	30% Coinsurance	Not covered	Prior authorization may be required. Limited 60 days per year.
	Durable medical equipment	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 exam per year.
	Children's glasses	No charge; deductible 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 .)		
<ul style="list-style-type: none"> • Abortion • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Children) • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Chiropractic care (Limited to 20 visits per year.) • Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.) 	<ul style="list-style-type: none"> • Hearing aids (Limited to 1 item per year every 3 years.) • Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.) 	<ul style="list-style-type: none"> • Routine foot care

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 Tennessee at 1-833-709-4735 (Relay 711); Tennessee Department of Commerce and Insurance, 500 James Robertson Pkwy., 10th Floor, Nashville, TN

37243-0565, Phone No. 1-615-741-2218 or 1-800-342-4029.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State [Plan](#) Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how 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: Tennessee Department of Commerce and Insurance, 500 James Robertson Pkwy., 10th Floor, Nashville, TN 37243-0565, Phone No. 1-615-741-2218 or 1-800-342-4029.

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? Not Applicable.

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 1-833-709-4735 (Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-709-4735 (Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-709-4735 (Relay 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-709-4735 (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 plan's overall deductible	\$700
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$20
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$700
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$600
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,380

Mia's Simple Fracture

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

■ The plan's overall deductible	\$700
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

English:	If you, or someone you are helping, have questions about Ambetter of Tennessee, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-709-4735 (Relay 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Tennessee y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-709-4735 (Relay 711).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Tennessee، ولم تكن بارعا باللغة الإنكليزية، ف لديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعد تعاني من حالة سمعية و/أو بصرية تعيق التواصل، ف لديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال ب خدمات الأعضاء على 1-833-709-4735 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of Tennessee 方面的問題，且不通英語，您有權利免費並及時以您的母語獲得幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-833-709-4735 (Relay 711)。
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter of Tennessee và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-833-709-4735 (Relay 711).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter of Tennessee에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-833-709-4735(Relay 711)번으로 가입자 서비스부에 연락해주시요.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Tennessee et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-833-709-4735 (Relay 711).
Laotian:	ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter of Tennessee, ຄະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໂດຮັບການຊ່ວຍເຫຼືອ ຄະ ຂໍມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ຄະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໂຕ້ເຍັນ ຄະ/ຫຼື ການເປັນຜູ້ທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໂດຮັບການຊ່ວຍເຫຼືອ ຄະ ການບໍລິການເປັນພິການໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ຄະ ທັນເວລາ. ຜູ້ອື່ນທີ່ໂດຮັບການບໍລິການເປັນພິການ ຫຼື ບໍລິການເປັນພິການ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໂດຍ 1-833-709-4735 (Relay 711).
Amharic:	እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter of Tennessee ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቁንቁዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የእይታ ችግር ካልዎት፣ ኢፓክ እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እስከዎ በ 1-833-709-4735 (Relay 711) የአስፈላጊ ሎቶች ን ያናግሩ።
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Tennessee hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-833-709-4735 (Relay 711).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિને Ambetter of Tennessee વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા છો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-833-709-4735 (Relay 711) પર સંપર્ચની સેવાઓનો સંપર્ક કરો.

Japanese:

ご自身やあなたが介護している他の人が、Ambetter of Tennesseeについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-833-709-4735 (Relay 711)のメンバーサービスにご連絡ください。

Tagalog:

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter of Tennessee, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulongan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-709-4735 (Relay 711).

Hindi:

अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter of Tennessee से जुड़े प्रश्न हैं और आप दोनों अंग्रेजी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-833-709-4735 (Relay 711) पर सदस्य सेवाएं से संपर्क करें.

Russian:

Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter of Tennessee, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-833-709-4735 (Relay 711).

Persian:

اگر شما یا فردی که دارید به او کمک می‌کنید، سوالی درباره Ambetter of Tennessee دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-833-709-4735 (Relay 711) تماس بگیرید.

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Statement of Non-Discrimination

Ambetter of Tennessee is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Tennessee Health Insurance Marketplace. Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. © 2023 Celtic Insurance Company. All rights reserved.
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If you, or someone you are helping, have questions about Ambetter of Tennessee, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-709-4735 (Relay 711). If you believe that Celtic Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-709-4735 (Relay 711). You may also submit a grievance by phone to 1-833-709-4735 (Relay 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>.

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