



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://ambetterhealth.com/2025-brochures.html>, or call 1-833-919-3213 (TTY 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 1-833-919-3213 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 individual / \$0 family. | See the Common Medical Events chart below for your cost for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. Medical visits and certain prescription drugs are covered before you meet your deductible (see additional information below). | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes, \$3,800 individual / \$7,600 family for prescription drug coverage . There are no other specific deductibles . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | For network providers : \$9,200 individual / \$18,400 family. Not applicable for out-of-network providers . | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See https://ambetterhealth.com/findad-oc or call 1-833-919-3213 (TTY 711) for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |



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 | \$50 Copay / visit | Not covered | Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full. |
| | Specialist visit | \$115 Copay / visit | Not covered | None |
| | Preventive care/screening/immunization | No charge | 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) | \$60 Copay / visit for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% 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) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambetterhealth.com/2025formulary . | Generic drugs | Tier 1a - Preferred Generic Retail: \$3 Copay / prescription Tier 1b - Generic Retail: \$35 Copay / prescription | 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 2.5 times monthly cost-sharing amount. |
| | Preferred brand drugs | Tier 2 - Retail: \$195 Copay / prescription | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days |

| 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) | |
| | Non-preferred brand drugs and Non-preferred generic drugs | Tier 3 - Retail: \$250 Copay / prescription; subject to Rx drug deductible | Not covered | retail and up to 90 days through mail order. Mail orders are subject to 2.5 times monthly cost-sharing amount. \$3,800 individual / \$7,600 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs . |
| | Specialty drugs | Tier 4 - Retail: 50% Coinsurance ; subject to Rx drug deductible | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. \$3,800 individual / \$7,600 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | \$2500 Copay / visit (\$1250 Copay / visit for facility; \$1250 Copay / visit for physician fee) | \$2500 Copay / visit (\$1250 Copay / visit for facility; \$1250 Copay / visit for physician fee) | None |
| | Emergency medical transportation | 50% Coinsurance | 50% 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 | \$60 Copay / visit | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$3000 Copay / day | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | No charge | Not covered | Prior authorization may be required. Covered No Limit. |
| | Outpatient services | Office Visit: \$50 Copay / visit; | Not covered | Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and |

| 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 need mental health, behavioral health, or substance abuse services | | Other Outpatient Services: 50% Coinsurance | | other practitioner office visits do not require prior authorization.) |
| | Inpatient services | \$3000 Copay / day | Not covered | Prior authorization may be required. Covered No Limit. |
| If you are pregnant | Office visits | \$50 Copay / visit | 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 | No charge | 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 | \$3000 Copay / day | 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). |
| If you need help recovering or have other special health needs | Home health care | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Rehabilitation services | Outpatient: 50% Coinsurance Inpatient: \$3000 Copay / day | Not covered | Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. |
| | Habilitation services | Outpatient: 50% Coinsurance Inpatient: \$3000 Copay / day | Not covered | Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: 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) | |
| | Skilled nursing care | \$3000 Copay / day | Not covered | Prior authorization may be required. Covered No Limit. |
| | Durable medical equipment | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 50% 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 | Not covered | Limited to 1 visit per year. |
| | Children's glasses | No charge | 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 (Except in cases of rape, incest, or when the life of the member is endangered) Acupuncture Bariatric surgery Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Dental care (Children) Hearing aids Long-term care | <ul style="list-style-type: none"> 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.) | | |
| <ul style="list-style-type: none"> Chiropractic care Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility) | <ul style="list-style-type: none"> Private-duty nursing (On home and outpatient basis only (inpatient excluded)) | <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 Health at 1-833-919-3213 (TTY 711); Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; Phone: 515-654-6600; 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: Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; Phone: 515-654-6600

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 1-833-919-3213 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-919-3213 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-919-3213 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-919-3213 (TTY 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 | \$0 |
| ■ Specialist copayment | \$115 |
| ■ Hospital (facility) copayment | \$3,000 |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$0 |
| Copayments | \$3,600 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,860 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$115 |
| ■ Hospital (facility) copayment | \$3,000 |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$0 |
| Copayments | \$3,400 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,820 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$115 |
| ■ Hospital (facility) copayment | \$3,000 |
| ■ Other coinsurance | 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*)

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

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$0 |
| Copayments | \$1,100 |
| Coinsurance | \$800 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row



| | |
|------------------------|---|
| English: | If you, or someone you are helping, have questions about Ambetter Health, 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 1-833-919-3213 (TTY 711). |
| Spanish: | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter Health 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 1-833-919-3213 (TTY 711). |
| Chinese: | 如果您，或是您正在協助的對象，有關於 Ambetter Health 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。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 1-833-919-3213 (TTY 711)。 |
| Vietnamese: | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter Health 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 1-833-919-3213 (TTY 711). |
| Serbo-Croatian: | Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter Health, a ne govorite engleski jezik, imate pravo na besplatnu i blagovremenu pomoć i informacije na sopstvenom jeziku. Ako Vi, ili neko kome pomažete, imate neki poremećaj sluha i/ili vida zbog kojeg je onemogućena komunikacija, imate pravo da besplatno i blagovremeno dobijete pomagala i pomoćne usluge. Obratite se odeljenju za pružanje usluga članovima pozivom na broj 1-833-919-3213 (TTY 711) da biste dobili usluge prevoda ili pomoćne usluge. |
| German: | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter Health 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 1-833-919-3213 (TTY 711). |
| Arabic: | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter Health، ولم تكن بارعًا باللغة الإنكليزية، فلديك 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، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بخدمات الأعضاء على (1-833-919-3213 (TTY 711)). |

| | |
|-----------------------------|--|
| Laotian: | ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter Health, ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໄດ້ທີ່ 1-833-919-3213 (TTY 711). |
| Korean: | 귀하 또는 귀하의 도움을 받는 분이 Ambetter Health에 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 1-833-919-3213 (TTY 711)번으로 가입자 서비스부에 연락해 주십시오. |
| Hindi: | अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter Health 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 1-833-919-3213 (TTY 711) पर सदस्य सेवाएं से संपर्क करें. |
| French: | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter Health 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 1-833-919-3213 (TTY 711). |
| Pennsylvanian Dutch: | Wann du, odder epper wer dir helft, hen Frooge iwwer Ambetter Health, un sin net proficent in Englisch, du hoscht die Recht um Helf zu griege un Information in dei Schprooch mitaus Koscht un in en zeitlich Manner. Wann du, odder epper wer dir helft, hen en Auditory un/odder Sehlich Condition die iss schlecht fer Communication, du hoscht die Recht Auxiliary Aids zu griege un Services mitaus Koscht un in en zeitlich Manner. Fer Iwwersetzing odder Auxiliary Services zu griege, sei so gut un ruff Member Services um 1-833-919-3213 (TTY 711). |
| Thai: | หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter Health และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันที่ หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันที่ หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-919-3213 (TTY 711) |

Tagalog:

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter Health, 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 pannikin 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 1-833-919-3213 (TTY 711).

Karen:

နု၊ မ့တမ့ၢ် ပုၤလၢနမၤစၢၤအီၤတဂၤ၊ မ့ၢ်အိၣ်ဒီးတၢ်သံကွၢ် ဘၣ်ဃး Ambetter Health, ဒီး မ့ၢ်တသ့ဘၣ် အဲကလံးကျိၣ်ဂ့ၤဂ့ၤအယိ, နအိၣ်ဒီး တၢ်ခွဲးတၢ်ယၢ်လၢ ကဟံးန့ၢ် တၢ်မၤစၢၤဒီး တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိၣ်တၢ်ကတိၤဒၣ်နဲ လၢတလၢ်ဘၣ် ကျိၣ်စ့ဒီး လၢတၢ်ဆၢကတီၢ် ဖုၣ်ကိၢ်အပူၤန့ၣ်လီၤ. နု၊ မ့တမ့ၢ် ပုၤလၢနမၤစၢၤအီၤတဂၤ၊ အိၣ်ဒီး တၢ်ကီတၢ်ခဲတၢ်အိၣ်သးဘၣ်ဃး တၢ်န့ၣ်ဟူတၢ် ဒီး /မ့တမ့ၢ် တၢ်ထံၣ် လၢအတြီယာ် တၢ်ဆဲးကျၢဆဲးကျိးအယိ, နအိၣ်ဒီး တၢ်ခွဲးတၢ်ယၢ်လၢ နကဒီးန့ၢ် တၢ်မၤစၢၤဆီၣ်ထွဲဒီး တၢ်တိၤစၢၤမၤစၢၤတဖၣ် လၢတလၢ်ဘၣ် ကျိၣ်စ့ဒီး လၢတၢ်ဆၢကတီၢ် ဖုၣ်ကိၢ်အပူၤန့ၣ်လီၤ. ဒ်သိနကဒီးန့ၢ် တၢ်ကတိၤကျိးထံ မ့တမ့ၢ် တၢ်မၤစၢၤဆီၣ်ထွဲ အတၢ်ဖဲးတၢ်မၤတဖၣ်အဂီၢ် ဝံသးစူၤ ဆဲးကျိး ဆူ တၢ်မၤစၢၤ ကရူၢ်ဖိဖဲ 1-833-919-3213 (TTY 711) န့ၣ်တက့ၢ်.

Russian:

Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter Health, 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 1-833-919-3213 (TTY 711).

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