# Ambetter from Meridian
# Elite Bronze: Limited Cost Sharing Plan Variation

**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://ambettermeridian.com/2025-brochures.html, or call 1-833-993-2426 (TTY 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 1-833-993-2426 (TTY Relay 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?** | $0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or 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://ambettermeridian.com/findadoc or call 1-833-993-2426 (TTY Relay 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 |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No charge | $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. Cost sharing waived at non-IHCP with IHCP referral. |
| | Specialist visit | No charge | $115 Copay / visit | Not covered | None Cost sharing waived at non-IHCP with IHCP referral. |
| | Preventive care/screening/ immunization | No charge | 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. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | $60 Copay / visit for laboratory & professional services<br>50% Coinsurance for x-ray & diagnostic imaging<br>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.<br><br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. Cost sharing waived at non-IHCP with IHCP referral. |
| | Imaging (CT/PET scans, MRIs) | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **https://ambettermeridian.com/2025formulary**. | Generic drugs | No charge | Tier 1a - Preferred Generic Retail: $3 Copay / prescription<br><br>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 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral. |
| | Preferred brand drugs | No charge | Tier 2 - Retail: $195 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 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral. |
| | Non-preferred brand drugs and Non-preferred generic drugs | No charge | Tier 3 - Retail: $250 Copay / prescription; subject to Rx drug deductible | 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 2.5x retail cost-sharing amount. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs. Cost sharing waived at non-IHCP with IHCP referral. |
| | Specialty drugs | No charge | 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 non-preferred brand and specialty drugs. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you need immediate** | Emergency room care | No charge | $2500 Copay / visit ($1250 Copay / visit for facility; | $2500 Copay / visit ($1250 Copay / visit for | None Cost sharing waived at non-IHCP with IHCP referral. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| **medical attention** | | | $1250 Copay / visit for physician fee) | facility; $1250 Copay / visit for physician fee) | |
| | Emergency medical transportation | No charge | 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. Cost sharing waived at non-IHCP with IHCP referral. |
| | Urgent care | No charge | $60 Copay / visit | Not covered | None Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | $3000 Copay / day | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge | No charge | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | Office Visit: $50 Copay / visit;<br>Other Outpatient Services: 50% 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.) Cost sharing waived at non-IHCP with IHCP referral. |
| | Inpatient services | No charge | $3000 Copay / day | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you are pregnant** | Office visits | No charge | $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 |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | | | | | described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral. |
| | Childbirth/delivery professional services | No charge | 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). Cost sharing waived at non-IHCP with IHCP referral. |
| | Childbirth/delivery facility services | No charge | $3000 Copay / day | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| | Rehabilitation services | No charge | Outpatient: 50% Coinsurance<br>Inpatient: $3000 Copay / day | Not covered | Outpatient: Prior authorization may be required. Outpatient rehabilitation is limited to the following: 30 combined visits per year for physical therapy and occupational therapy (combined with chiropractic care), 30 visits per year for speech therapy and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be required. Covered No Limit.<br>Cost sharing waived at non-IHCP with IHCP referral. |
| | Habilitation services | No charge | Outpatient:50% Coinsurance<br>Inpatient: $3000 Copay / day | Not covered | Outpatient: Prior authorization may be required. Habilitation outpatient services are limited to the following: 30 combined visits per year for physical therapy and occupational therapy (combined with chiropractic care), 30 visits per year for speech therapy, and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | | | | | for a mental health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be required. Covered No Limit.<br>Cost sharing waived at non-IHCP with IHCP referral. |
| | Skilled nursing care | No charge | $3000 Copay / day | Not covered | Prior authorization may be required. Limited to 45 days per year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Durable medical equipment | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| | Hospice services | No charge | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Not covered | Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Children's glasses | No charge | No charge | Not covered | Limited to 1 item per year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Children's dental check-up | Not covered | 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 when the life of the member is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

**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 surgery per lifetime)
- Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care))
- Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)
- Routine foot care
- Weight loss programs (Weight loss programs under the supervision of a physician & obesity counseling)

**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 Meridian at 1-833-993-2426 (TTY Relay 711); Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Michigan Health Options at 1-877-527-9431; 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: Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442.

**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 1-833-993-2426 (TTY Relay 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-993-2426 (TTY Relay 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-993-2426 (TTY Relay 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-993-2426 (TTY 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 | $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 | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

### 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 | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

### 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 | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

| | |
|---|---|
| **English:** | If you, or someone you are helping, have questions about Ambetter from Meridian, 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 1-833-993-2426 (TTY Relay 711). |
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Meridian 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 1-833-993-2426 (TTY Relay 711). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Meridian، 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 تساعده 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 بـ خدمات الأعضاء على 1-833-993-2426 (TTY Relay 711). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Meridian 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 1-833-993-2426 (TTY Relay 711)。 |
| **Syriac:** | ܐܢ ܐܢܬ ܐܘ ܡܢ ܕܐܢܬ ܥܒܕ ܠܗ ܥܕܪܐ ܥܠ Ambetter from Meridian ܘܠܐ ܡܬܟܠܡ ܐܢܓܠܝܙܝܐ، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܩܒܠ ܥܕܪܐ ܘܝܕܥܢܐ ܒܠܫܢܬܟ ܒܠܐ ܡܫܘܡ ܘܒܙܡܢ ܡܬܐܡ. ܐܢ ܐܢܬ ܐܘ ܡܢ ܕܐܢܬ ܥܒܕ ܠܗ ܥܕܪܐ ܥܠ ܡܬܟܠܡ ܒܥܐ ܠܫܡܥ ܘ/ܐܘ ܠܚܙܐ، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܩܒܠ ܥܕܪܐ ܘܫܝܪܘܬܐ ܐܚܪܢܝܬ ܒܠܐ ܡܫܘܡ ܘܒܙܡܢ ܡܬܐܡ. ܠܩܒܠ ܫܝܪܘܬܐ ܕܬܪܓܡܢܘܬܐ ܐܘ ܫܝܪܘܬܐ ܐܚܪܢܝܬ، ܒܥܝ ܠܩܫܪܐ ܥܡ ܫܝܪܘܬܐ ܕܐܒܪܐ ܥܠ 1-833-993-2426 (TTY Relay 711). |
| **Vietnamese:** | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Meridian 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 1-833-993-2426 (TTY Relay 711). |
| **Albanian:** | Nëse ju, ose dikush që po ndihmoni, keni pyetje rreth Ambetter from Meridian dhe nuk e zotëroni gjuhën angleze, ju gëzoni të drejtën të merrni ndihmë dhe informacione në gjuhën tuaj, falas dhe menjëherë. Nëse ju, ose dikush që po ndihmoni, keni një problem me dëgjimin dhe/ose shikimin, që ju pengon komunikimin, ju gëzoni të drejtën të merrni mjete dhe shërbime ndihmëse, falas dhe menjëherë. Për të marrë shërbime përkthimi ose ndihmëse, kontaktoni Shërbimet e anëtarëve në numrin 1-833-993-2426 (TTY Relay 711). |

| | |
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| **Korean:** | 귀하 또는 귀하의 도움을 받는 분이 Ambetter from Meridian에 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 1-833-993-2426 (TTY Relay 711)번으로 가입자 서비스부에 연락해주십시오. |
| **Bengali:** | আপনি অথবা অন্য কেউ যাকে আপনি সাহায্য করছেন তার Ambetter from Meridian নিয়ে প্রশ্ন থেকে থাকলে ও ইংরাজিতে সড়গড় না হলে নিখরচায় ও সময় মতো আপনার নিজের ভাষাতে সাহায্য ও তথ্য পাওয়ার অধিকার রয়েছে। আপনি বা অন্য কেউ যাকে আপনি সাহায্য করছেন তার শ্রবণ এবং/অথবা দৃশ্যগত রোগাবস্থা থেকে থাকে যা কমিউনিকেশনকে বিলম্বিত করে সে ক্ষেত্রে আপনার নিখরচায় ও সময় মতো সহায়ক ও পরিষেবা পাওয়ার অধিকার রয়েছে। অনুবাদ ও সহায়ক পরিষেবা পেতে অনুগ্রহ করে 1-833-993-2426 (TTY Relay 711)-এ সদস্য পরিষেবাসমূহ-এর সাথে যোগাযোগ করুন। |
| **Polish:** | Jeśli Ty lub osoba, której pomagasz, macie pytania dotyczące Ambetter from Meridian, ale nie posługujecie się biegle językiem angielskim, macie prawo do uzyskania pomocy i informacji w swoim języku bez dodatkowych kosztów i w odpowiednim czasie. Jeśli Ty lub osoba, której pomagasz, macie problemy ze słuchem i/lub wzrokiem, które utrudniają komunikację, macie prawo do otrzymania pomocy i usług pomocniczych bez dodatkowych kosztów i w odpowiednim czasie. Aby uzyskać tłumaczenie lub usługi pomocnicze, należy skontaktować się z Usługi członkowskie pod numerem 1-833-993-2426 (TTY Relay 711). |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Meridian 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 1-833-993-2426 (TTY Relay 711). |
| **Italian:** | Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Meridian e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-833-993-2426 (TTY Relay 711). |
| **Japanese:** | ご自身やあなたが介護している他の人が、Ambetter from Meridian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、1-833-993-2426 (TTY Relay 711)のメンバーサービスにご連絡ください。 |

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| **Russian:** | Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Meridian, 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 1-833-993-2426 (TTY Relay 711). |
| **Serbo-Croatian:** | Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter from Meridian, 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 1-833-993-2426 (TTY Relay 711) da biste dobili usluge prevoda ili pomoćne usluge. |
| **Tagalog:** | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Meridian, 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 tinutulungan, 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 1-833-993-2426 (TTY Relay 711). |