




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit

<https://ambetter.nhhealthyfamilies.com/2025-brochures.html>, or call 1-844-265-1278 (TTY 1-855-742-0123). 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 1-844-265-1278 (TTY 1-855-742-0123) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or \$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> visits, and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> (see additional information below). | 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> : \$7,800 individual / \$15,600 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://ambetter.nhhealthyfamilies.com/findadoc or call 1-844-265-1278 (TTY 1-855-742-0123) 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 |
|--|--|---|--|--|--|
| | | 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 | \$30 Copay / visit; deductible does not apply | Not covered | Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Specialist visit | No charge | \$60 Copay / visit; deductible does not apply | Not covered | None Cost sharing waived at non-IHCP with IHCP referral . |
| | Preventive care/screening/immunization | No charge | 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. Cost sharing waived at non-IHCP with IHCP referral . |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 25% Coinsurance for laboratory & professional services 25% Coinsurance for x-ray & diagnostic imaging 25% 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. Cost sharing waived at non-IHCP with IHCP referral . |
| | Imaging (CT/PET scans, MRIs) | No charge | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Generic drugs | No charge | Tier 1a - Preferred Generic Retail: \$15 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 3x retail cost-sharing |

| 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://ambetter.nhhealthyfamilies.com/2025formulary . | | | deductible does not apply Tier 1b - Generic Retail: \$15 Copay / prescription; deductible does not apply | | amount. FDA approved and over-the-counter contraceptives are not subject to cost-share. Cost sharing waived at non-IHCP with IHCP referral . |
| | Preferred brand drugs | No charge | Tier 2 - Retail: \$30 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. FDA approved and over-the-counter contraceptives are not subject to cost-share. Cost sharing waived at non-IHCP with IHCP referral . |
| | Non-preferred brand drugs | No charge | Tier 3 - Retail: \$60 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 30 days through mail order. FDA approved and over-the-counter contraceptives are not subject to cost-share. Cost sharing waived at non-IHCP with IHCP referral . |
| | Specialty drugs | No charge | Tier 4 - Retail: \$250 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 30 days through mail order. FDA approved and over-the-counter contraceptives are not subject to cost-share. Cost sharing waived at non-IHCP with IHCP referral . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 25% 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 | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| If you need immediate medical attention | Emergency room care | No charge | 25% Coinsurance | 25% Coinsurance | None Cost sharing waived at non-IHCP with IHCP referral . |
| | Emergency medical transportation | No charge | 25% Coinsurance | 25% 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 , |

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| | | 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) | |
| | | | | | you may be subject to balance billing . Cost sharing waived at non-IHCP with IHCP referral . |
| | Urgent care | No charge | \$45 Copay / visit; deductible does not apply | \$45 Copay / visit | None Cost sharing waived at non-IHCP with IHCP referral . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 25% 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 | 25% Coinsurance | 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: \$30 Copay / visit; deductible does not apply; Other Outpatient Services: 25% 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 | 25% Coinsurance | 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 | \$30 Copay / visit; deductible does not apply | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation. 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). Cost sharing waived at non-IHCP with IHCP referral . |
| | Childbirth/delivery professional services | No charge | 25% Coinsurance | Not covered | Prior authorization not required for delivery professional services or delivery facility services. 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 |
| | Childbirth/delivery facility services | No charge | 25% Coinsurance | Not covered | |

| 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) | |
| | | | | | elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral . |
| If you need help recovering or have other special health needs | Home health care | No charge | 25% 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: \$30 Copay / visit; deductible does not apply; Inpatient: 25% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Outpatient rehabilitation services are limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech 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. Cost sharing waived at non-IHCP with IHCP referral . |
| | Habilitation services | No charge | Outpatient: \$30 Copay / visit; deductible does not apply Inpatient: 25% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Habilitation services are limited to 20 visits per year per therapy (occupational therapy, physical therapy and speech therapy). Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Skilled nursing care | No charge | 25% Coinsurance | Not covered | Prior authorization may be required. Limited to 100 days per year in a facility. Cost sharing waived at non-IHCP with IHCP referral . |
| | Durable medical equipment | No charge | 25% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Hospice services | No charge | 25% 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; deductible does not apply | Not covered | Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral . |
| | Children's glasses | No charge | No charge; deductible does not apply | Not covered | Limited to 1 item per year. 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) | |
| | 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 .) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the member is endangered) • Cosmetic surgery • Dental care (Children) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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"> • Acupuncture • Bariatric surgery • Chiropractic care (Limited to 12 visits per year) | <ul style="list-style-type: none"> • Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.) • Hearing aids (Benefits are available for one hearing aid per ear each time a hearing aid prescription changes.) • Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility) | <ul style="list-style-type: none"> • Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.) • 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 from New Hampshire Healthy Families at 1-844-265-1278 (TTY 1-855-742-0123); New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.; 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: New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.

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 1-844-265-1278 (TTY 1-855-742-0123).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-265-1278 (TTY 1-855-742-0123).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-265-1278 (TTY 1-855-742-0123).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-265-1278 (TTY 1-855-742-0123).

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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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.

English:

If you, or someone you are helping, have questions about Ambetter from NH Healthy Families, 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 1-844-265-1278 (TTY 1-855-742-0123).

Spanish:

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from NH Healthy Families 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 1-844-265-1278 (TTY 1-855-742-0123).

French:

Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families 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 1-844-265-1278 (TTY 1-855-742-0123).

Chinese:

如果您或您正在協助的對象有關於 Ambetter from NH Healthy Families 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得幫助和資訊。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 1-844-265-1278 (TTY 1-855-742-0123)。

Nepali:

यदि तपाईं स्वयं वा तपाईंले मदद गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सँग सम्बन्धित प्रश्नहरू छन् र तपाईं दुवै अंग्रेजीमा निपुण हुनुहुन्न भने तपाईंसँग निःशुल्क रूपमा र समयमै आफ्नो भाषामा मदद र जानकारी प्राप्त गर्ने अधिकार छ। यदि तपाईं वा तपाईंले मदद गरिरहनुभएको व्यक्तिसँग सञ्चारमा बाधा पुऱ्याउने श्रवण र/वा दृश्यसम्बन्धी समस्या छ भने तपाईंसँग निःशुल्क रूपमा र समयमै सहायक उपकरण र सेवाहरू प्राप्त गर्ने अधिकार छ। अनुवाद वा सहायक सेवाहरू प्राप्त गर्न कृपया 1-844-265-1278 (TTY 1-855-742-0123) मा सदस्य सेवाहरू लाई सम्पर्क गर्नुहोस्।

Vietnamese:

Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from NH Healthy Families 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 dịch thuật hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-844-265-1278 (TTY 1-855-742-0123).

Portuguese:

Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Peach State Health Plan e não falar inglês, tem direito a obter ajuda e informações no seu idioma, sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem direito a receber equipamentos ou serviços de assistência, sem qualquer custo e de forma atempada. Para ter acesso a traduções ou a serviços de assistência, contacte os "Member Services" (Serviços de Membros) através do número 1-844-265-1278 (TTY 1-855-742-0123).

Greek:

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις σχετικά με το Ambetter from NH Healthy Families και δεν γνωρίζετε καλά την αγγλική γλώσσα, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση και εγκαίρως. Εάν εσείς ή κάποιος που βοηθάτε έχετε δυσκολία στην όραση ή/και την ακοή, που εμποδίζει την επικοινωνία, έχετε το δικαίωμα να λάβετε επικοινωνικά βοηθήματα και υπηρεσίες χωρίς χρέωση και εγκαίρως. Για μεταφραστικές ή βοηθητικές υπηρεσίες, επικοινωνήστε με την Εξυπηρέτηση Μελών στο 1-844-265-1278 (TTY 1-855-742-0123).

Arabic:

إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from NH Healthy Families، ولم تكن تجيد التحدث باللغة الإنكليزية، ف لديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت تعاني، أنت أو أي شخص تساعد، 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 بخدمات الأعضاء على 1-844-265-1278 (TTY 1-855-742-0123).

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| Serbo-Croatian: | Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter from NH Healthy Families, 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 1-844-265-1278 (TTY 1-855-742-0123) da biste dobili usluge prevoda ili pomoćne usluge. |
| Indonesian: | Jika Anda atau seseorang yang Anda bantu memiliki pertanyaan tentang Ambetter from NH Healthy Families, tetapi tidak mahir berbahasa Inggris, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda secara gratis dan tepat waktu. Jika Anda atau seseorang yang Anda bantu memiliki kondisi pendengaran dan/atau penglihatan yang menghambat komunikasi, Anda berhak menerima bantuan dan layanan tambahan secara gratis dan tepat waktu. Untuk menerima layanan tambahan atau terjemahan, silakan hubungi Layanan Anggota di 1-844-265-1278 (TTY 1-855-742-0123). |
| Korean: | 귀하 또는 귀하의 도움을 받는 분이 Ambetter from NH Healthy Families에 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. 통역 또는 보조 서비스를 받으시려면 1-844-265-1278(TTY 1-855-742-0123) 번으로 가입자 서비스부에 연락해주시요. |
| Russian: | Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from NH Healthy Families, 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 по номеру 1-844-265-1278 (TTY 1-855-742-0123). |
| French Creole: | Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from NH Healthy Families, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-844-265-1278 (TTY 1-855-742-0123). |
| Bantu: | Nimba wewe, canke undi muntu wewe se uri gufasha, yoba afise ico asiguza kijanye na Ambetter from NH Healthy Families, kandi adatahura neza icongereza, ufise agateka ko kurungikirwa ubufasha n'amakuru ku buntu kandi mu kiringo gikwiye. Nimba wewe, canke undi wewe se uri gufasha, afise nkenerwa zo kumva na/canke kuraba bibuza itumanako, ufise agateka ko kurungikirwa agafasha kumviriza na serevise atanyishu kandi mu kiringo gikwiye. Kugira urungikirwe serevise z'ubusiguzi canke agafasha kumviriza, turagusavye yaga na Serevise z'Abanyamuryango kuri 1-844-265-1278 (TTY 1-855-742-0123). |
| Polish: | Jeśli Ty lub osoba, której pomagasz, macie pytania dotyczące Ambetter from NH Healthy Families, 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 1-844-265-1278 (TTY 1-855-742-0123). |

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