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/2026-brochures.html or call 1-833-543-3145 (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 1-833-543-3145 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $1,350 Individual / $2,700 Family. Out-of-network providers: $15,000 Individual / $30,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, primary care and urgent care 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $9,200 Individual / $18,400 Family. For out-of-network providers: $25,000 Individual / $50,000 Family.	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/findadoc or call 1-833-543-3145 (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

Important Questions	Answers	Why This Matters:
		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	$35 Copay / visit; deductible does not apply	60% Coinsurance	Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full, deductible does not apply.
	Specialist visit	$60 Copay / visit	60% Coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	60% Coinsurance	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)	$20 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	60% Coinsurance for laboratory & professional services 60% Coinsurance for x-ray & diagnostic imaging 60% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	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	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or	Generic drugs	Tier 1a - Preferred Generic Retail: $3 Copay / prescription;	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30

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)	
condition More information about **prescription drug coverage** is available at **https://ambetterhealth.com/2026formulary**.		deductible does not apply Tier 1b - Generic Retail: $30 Copay / prescription; deductible does not apply		days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs	Tier 2 - Retail: $80 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 2.5x retail cost-sharing amount.
	Non-preferred brand drugs and Non-preferred generic drugs	Tier 3 - Retail: $100 Copay / prescription; deductible does not apply	Not covered	
	Specialty drugs	Tier 4 - Retail: 30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance	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; deductible does not apply	60% Coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 Copay / visit; deductible does not apply; Other Outpatient Services: 50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) Note: Services (excluding Emergency Room Care / Emergency Services) rendered by an out-of-network provider are not covered under this plan, with the exception of two (2) sessions per year for diagnosis/assessment by a licensed mental health provider (covered at applicable INN cost share).
	Inpatient services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$35 Copay / visit; deductible does not apply	60% Coinsurance	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	50% Coinsurance	60% Coinsurance	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
	Childbirth/delivery facility services	50% Coinsurance	60% Coinsurance	

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)	
				(i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 100 visits per year.
	Rehabilitation services	Outpatient: $35 Copay / visit; deductible does not apply Inpatient: 50% Coinsurance	Outpatient: 60% Coinsurance Inpatient: 60% Coinsurance	Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational and physical therapy); no limit applies for speech therapy or pulmonary therapy; limited to 36 visits per year for cardiac 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: $35 Copay / visit; deductible does not apply Inpatient: 50% Coinsurance	Outpatient: 60% Coinsurance Inpatient: 60% Coinsurance	Outpatient: Prior authorization may be required. Limited to 20 visits per year per therapy (occupational and physical therapy); no limit applies for speech therapy or pulmonary therapy; limited to 36 visits per year for cardiac therapy. (See the Schedule of Benefits for applicable cost share when provided for a non-medical diagnosis.) Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 150 days per year.
	Durable medical equipment	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	50% Coinsurance	60% Coinsurance	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	Covered up to $38.50; deductible does not apply	Limited to 1 visit per year. Out-of-network provider eye exam covered up to $38.50.
	Children's glasses	No charge; deductible	Covered up to $50;	Limited to 1 item per year. Out-of-network

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)	
		does not apply	deductible does not apply	provider frames or contacts covered up to $50, see schedule for lens limit.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except in cases when the life of the member is endangered)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Limited to 12 visits per year)
- Chiropractic care (Limited to 26 visits per year. Visits in excess of 26 require prior authorization.)
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)
- Hearing aids (Limited to 1 per ear per year)
- Private-duty nursing (Limited to 82 visits per year)
- Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply 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 Health at 1-833-543-3145 (TTY 711); Missouri Department of Insurance, P.O. Box 690, Jefferson City, MO 65102-0690, Phone: 1-800-726-7390; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Missouri Consumer Assistance Program at 1-800-726-7390; 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: Missouri Department of Insurance, P.O. Box 690, Jefferson City, MO 65102-0690, Phone: 1-800-726-7390. Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Consumer Assistance Program at 1-800-726-7390.

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 the 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 1-833-543-3145 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-543-3145 (TTY 711).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-543-3145 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-543-3145 (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	$1,350
Specialist copayment	$60
Hospital (facility) coinsurance	50%
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*	$1,350
Copayments	$70
Coinsurance	$4,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,780**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,350
Specialist copayment	$60
Hospital (facility) coinsurance	50%
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*	$1,200
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,350
Specialist copayment	$60
Hospital (facility) coinsurance	50%
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*	$1,350
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,050**

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

English:	If you, or someone you're helping, have questions about any of the Ambetter Health offerings, 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're 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 1-833-543-3145 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de alguno de los ofrecimientos 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 1-833-543-3145 (TTY 711).
Chinese:	如果您或您正在協助的對象對 Ambetter Health 所提供的任何服務有問題，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訊資訊。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1-833-543-3145 (TTY 711)。
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về bất kỳ dịch vụ nào của 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 1-833-543-3145 (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 1-833-543-3145 (TTY 711) da biste dobili usluge prevoda ili pomoćne usluge.
German:	Falls Sie oder eine Person, der Sie helfen, Fragen zu Angeboten von 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 Mitgliederservice unter 1-833-543-3145 (TTY 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده 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 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 1-833-543-3145 (TTY 711).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter Health 제품에 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 1-833-543-3145 (TTY 711)번으로 가입자 서비스부에 연락해주십시오.

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Russian:	Если у вас или у лица, которому вы помогаете, возникли вопросы о любых предложениях 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, есть нарушения слуха или зрения, которые препятствуют 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 телефону 1-833-543-3145 (TTY 711).
French:	Si vous même ou une personne que vous aidez avez des questions à propos de l'une des offres 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 les Services aux membres au 1-833-543-3145 (TTY 711).
Pennsylvania Dutch:	Wann du, odder epper wer dir helft, hen Frooge iwwer Ambetter Health, un sin net proficient 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 1-833-543-3145 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa alinman sa mga inaalok ng 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 tinutulungan, 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 1-833-543-3145 (TTY 711).
Persian:	دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به Ambetter Healthاگر شما یا فردی که دارید به او کمک می کنید، سؤالی درباره زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات تماس بگیرید.(TTY 711) 1-833-543-3145امدادی لطفاً با خدمات اعضا به شماره
Cushite:	Isin, ykn namni biraa isin gargaartan, dhiyeessiwwan Ambetter Health ilaalchisee gaaffii qabdu yoo ta'ee fi Afaan Ingiliffaa hin beektanu taanan, yeroodhaan afaan barbaaddaniin kaffaltii tokko malee odeeffannoo barbaaddan argachuudhaaf mirga qabdu. Isin, ykn namni isin gargaartan, rakkoo dhageettii fi/ykn agartii kan haasaa keessan irratti dhiibbaa qabu qabdu taanan, gargaarsa dhageettii argachuu fi tajaajiloota kaffaltii malee argachuudhaaf mirga qabdu. Tajaajiloota hiikkaa afaanii fi dhageettii argachuudhaaf, maaloo Tajaajiloota Maamilaa karaa 1-833-543-3145 (TTY 711) qunnamaa.
Portuguese:	Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca da Ambetter Health 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 [Serviços de Membros] através do número 1-833-543-3145 (TTY 711).
Amharic:	እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ስለ Ambetter Health ጥያቄ ካለዎት እና እንግሊዝኛ ብቁ ካልሆኑ፣ ያለምንም ወጪ እና በጊዜው በቋንቋዎ እርዳታ እና መረጃ የማግኘት መብት አልዎት። እርስዎ ወይም ሌላ የሚያግዙት ሰው፣ ግንኙነትን የሚያደናቅፍ የመስማት እና/ወይም የእይታ ችግር ካልዎት፣ አጋዥ እርዳታዎችን እና አገልግሎቶችን ያለ ምንም ወጪ እና በጊዜው የመቀበል መብት አልዎት። የትርጉም ወይም ረዳት አገልግሎቶችን ለማግኘት እባክዎ በ 1-833-543-3145 (TTY 711) የአባል አገልግሎቶች ን ያናግሩ።

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