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: $3,500 Individual / $7,000 Family. Out-of-network providers: $10,000 Individual / $20,000 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, specialist, 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: $7,250 Individual / $14,500 Family. For out-of-network providers: Not applicable Individual / Not applicable 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	$5 Copay / visit; deductible does not apply	50% 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	$40 Copay / visit; deductible does not apply	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% 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)	$15 Copay / visit; deductible does not apply for laboratory & professional services $40 Copay / visit; deductible does not apply for x-ray & diagnostic imaging 20% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	50% Coinsurance 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	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,	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered

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)	
	MRIs)			No Limit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambetterhealth.com/2026formulary**.	Generic drugs	Tier 1a - Preferred Generic Retail: $3 Copay / prescription; deductible does not apply Tier 1b - Generic Retail: $3 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.
	Preferred brand drugs	Tier 2 - Retail: $35 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.
	Non-preferred brand drugs and Non-preferred generic drugs	Tier 3 - Retail: 40% Coinsurance	Not covered	
	Specialty drugs	Tier 4 - Retail: 50% 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)	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% 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 water ambulance provider, you may be subject to balance billing.

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)	
	Urgent care	$40 Copay / visit; deductible does not apply	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $5 Copay / visit; deductible does not apply; Other Outpatient Services: 20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$5 Copay / visit; deductible does not apply	50% 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	20% Coinsurance	50% 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 (i.e., ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	50% 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)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Limited to 30 visits per year.
	Rehabilitation services	Outpatient: $15 Copay / visit; deductible does not apply Inpatient: 20% Coinsurance	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Outpatient: Prior authorization may be required. Limited to a combined 25 visit limit for occupational, speech and physical therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 30 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	Outpatient: $15 Copay / visit; deductible does not apply Inpatient: 20% Coinsurance	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Outpatient: Prior authorization may be required. Limited to a combined 25 visit limit for occupational, speech and physical therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 30 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Limited to 30 days per year.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	20% Coinsurance	50% 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 does not apply	Covered up to $50; deductible does not apply	Limited to 1 item per year. Out-of-network provider frames or contacts covered up to

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)	
				$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 (Adult)
- Dental care (Children)
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture (Limited to 12 visits per year)
- Chiropractic care
- Hearing aids (Limited to 1 per ear every 4 years)
- Private-duty nursing (Limited to 85 visits per year)
- 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); Oklahoma Insurance Department, 400 NE 50th St., Oklahoma City, OK 73105, Phone: 800-522-0071; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Oklahoma Consumer Assistance Program at 1-800-522-0071; 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: Oklahoma Insurance Department, 400 NE 50th St., Oklahoma City, OK 73105, Phone: 800-522-0071. Additionally, a consumer assistance program can help you file your appeal. Contact Oklahoma Consumer Assistance Program at 1-800-522-0071.

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	$3,500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$3,500
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

The plan's overall deductible	$3,500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$3,500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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).
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).
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)。
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.
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 بخدمات الأعضاء على 1-833-543-3145 (TTY 711).
Burmese:	အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် Ambetter Health ၏ ကမ်းလှမ်းချက်များနှင့် ပတ်သက်၍ မေးခွန်းများ မေးလိုပြီး အင်္ဂလိပ်လို ကျွမ်းကျင်စွာ မပြောနိုင်ပါက၊ သင့်တွင် အကူအညီနှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် ဆက်သွယ်ရေးကို အဟန့်အတားဖြစ်စေသော အကြားအာရုံ နှင့်/သို့မဟုတ် အမြင်အာရုံနှင့် သက်ဆိုင်သော အခြေအနေတစ်ခုရှိပါက၊ သင့်တွင် အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကို အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ ဘာသာပြန် သို့မဟုတ် အရန်ဝန်ဆောင်မှုများကို လက်ခံရယူရန် 1-833-543-3145 (TTY 711) ရှိ အဖွဲ့ဝင် ဝန်ဆောင်မှုများကို ဆက်သွယ်ပါ။

AMB25-AHS-C-00009-OK

Hmong:	Yog tias koj, lossis tus uas koj tabtom pab, muaj lus nug txog ib yam ntawm Ambetter Health cov kev pab, thiab tsis txawj hais lus Askiv zoo, koj muaj cai tau txais kev pab thiab cov ntaub ntawv hauv koj hom lus yam tsis muaj nqi thiab raws sijhawm. Yog tias koj, los sis ib tug neeg twg uas koj tab tom pab, muaj tsos mob txog kev hnov lus thiab/los sis kev pom kev uas cuam tshuam txog kev sib txuas lus, koj muaj cai kom tau txais cov kev pab thiab cov kev pab cuam ntxiv yam tsis tau them dab tsi li thiab kom tau raws sij hawm. Txhawm rau kom tau txais cov kev pab cuam txhais ntawv los sis kev pab ntxiv, thov tiv tauj Cov Chaw Muab Kev Pab Cuam Tswv Cuab tau ntawm 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).
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).
Laotian:	ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບສິ່ງທີ່ Ambetter Health ມອບໃຫ້ ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ ການບໍລິການສະມາຊິກ ໄດ້ທີ່ 1-833-543-3145 (TTY 711).
Thai:	หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter Health และไม่ชำนาญในการใช้ภาษาอังกฤษคุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงทีหากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสารคุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-543-3145 (TTY 711)
Urdu:	اگر آپ، یا جس کی آپ مدد کر رہے ہیں وہ Ambetter Health کے بارے میں سوالات کرنا چاہتے ہیں، اور وہ انگریزی میں ماہر نہیں ہیں، تو آپ کو اپنی زبان میں بلا معاوضہ اور بروقت مدد اور معلومات حاصل کرنے کا حق ہے۔ اگر آپ، یا جس کی آپ مدد کر رہے ہیں، انہیں سماعت اور/یا بصارت میں کوئی پریشانی درپیش ہے جس سے مواصلت میں رکاوٹ پیدا ہوتی ہے، تو آپ کو مفت اور بر وقت معاون امداد اور خدمات حاصل کرنے کا حق ہے۔ ترجمہ یا معاون خدمات حاصل کرنے کے لیے، براہ کرم (TTY 711) 1-833-543-3145 پر ممبر سروسز سے رابطہ کریں۔
Cherokee:	ᎬᏗ ᏂᏲᎢ ᎢᎯᏍᏉ, ᎠᎴ ᎩᎶᎢ ᎯᎠ ᏕᏣᏔᏅᏔᏅ ᎠᏍᏕᏣᏎ, ᎤᏙᏓᏆᎠ ᎤᏍᏓᏔ ᎤᏣᏗᏨ ᎠᏓᏅᏖᏍ_ᏕᎪᎠ, ᎠᎴ ᏕᏩᏔᏅᎥᏍᏕ ᎲᏍᏗ ᎠᏏᎾᏎ ᎾᏍᎩ ᏗᎪᏪᎵ Ambetter Health ᎠᎾᏓᎪᏪᎯᎢ, ᎢᎯᏍᏉ ᎤᏙᏓᏆᎠ ᏃᎴ ᎠᏗᏍᎩ ᏰᏣᏉ ᎠᏴᎠ ᎠᏍᏕᏣᏎ ᎠᎴ ᏕᏁᎾᏗᏎ ᎬᏗ ᎢᎯᏍᏉ ᎢᎬᏁᎢᏍᏗ ᎰᎾᏂᏟ ᏎᏗ ᏧᎬᏩᎶᏗ ᎠᎴ ᎬᏗ ᎠᎢᏳᏩᏂᎸᎯ ᎠᎬᏔᏗᏟ. ᎬᏗ ᏂᏲᎢ ᎢᎯᏍᏉ, ᎠᎴ ᎩᎶᎢ ᎯᎠ ᏕᏣᏔᏅᏔᏅ ᎠᏍᏕᏣᏎ, ᎤᏙᏓᏆᎠ ᏃᎴ ᎠᏍᏛᏍᎦᏍ ᎠᎴ/ᎠᎴ ᏗᏥᏩᏍᏓᏅᎯ ᏥᏳᎩ ᏍᎩ ᎠᏔᎲᎯᏎ ᎤᏗᎴᎬᎢ, ᎢᎯᏍᏉ ᎤᏙᏓᏆᎠ ᏃᎴ ᎠᏗᏍᎩ ᏰᏣᏉ ᏓᏓᏂᎸᏕ ᎠᏅᎯᏎ ᎠᏍᏕᏣᏎ ᎠᎴ ᎤᏬᏭᏂ ᎰᎾᏂᏟ ᏎᏗ ᏧᎬᏩᎶᏗ ᎠᎴ ᎬᏗ ᎠᎢᏳᏩᏂᎸᎯ ᎠᎬᏔᏗᏟ. ᏰᏣᏉ ᏓᏓᏂᎸᏕ ᎠᏁᏍᏗᏎ ᎠᎴ ᎠᏅᎯᏎ ᎤᏬᏭᏂ, ᎠᏔᎲᎯᏎ ᎠᏒᏂᏎ ᏴᎾ ᎤᏬᏭᏂ ᎰᎾᏂᏟ 1-833-543-3145 (TTY 711).
Persian:	اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter Health دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-833-543-3145 (TTY 711) تماس بگیرید.

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