



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 ?	\$2,500 individual / \$5,000 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 : \$6,000 individual / \$12,000 family. Not applicable for out-of-network providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See https://ambetterhealth.com/findado 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 work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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	\$20 Copay / visit; deductible does not apply	Not covered	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	\$45 Copay / visit; deductible does not apply	Not covered	None
	Preventive care/screening /immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance for laboratory & professional services 20% Coinsurance for x-ray & diagnostic imaging 20% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs	Tier 1a - Preferred Generic Retail: \$3 Copay / prescription; deductible does not	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

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)	
More information about prescription drug coverage is available at https://ambetterhealth.com/2026formulary		apply Tier 1b - Generic Retail: \$10 Copay / prescription; deductible does not apply		cost-sharing amount.
	Preferred brand drugs	Tier 2 - Retail: \$50 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: 20% 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	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	Not covered	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.
	Urgent care	\$45 Copay / visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 Copay / visit; deductible does not apply; Other Outpatient Services: 20% 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.)
	Inpatient services	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$20 Copay / visit; deductible does not apply	Not covered	Prior authorization not required for deliveries within the standard time frame 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	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 visits per year.
	Rehabilitation services	Outpatient: 20% Coinsurance Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 35 combined visits per year (combined with chiropractic care). Note: Limits do not apply to treatment or care determined to be medically necessary as a result of and related to an acquired brain injury, for treating developmental delays or

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)	
				for any mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: 20% Coinsurance Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 35 visits per year. Note: Limits do not apply when treatment is provided for a mental health/substance use disorder diagnosis or developmental delays. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 25 days per year.
	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
- Abortion (Except when the life of the member is endangered if the fetus were carried to term or delivered) - 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)	Hearing aids (Limited to 2 items every 3 years)	Routine foot care

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

- Chiropractic care (Limited to 35 combined visits per year (combined with outpatient rehabilitation therapy))
- Private-duty nursing (Available on an inpatient basis only (outpatient & home excluded))

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); Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030, Phone: 1-800-252-2439; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Texas Consumer Assistance Program at 1-800-252-3439; 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: Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030, Phone: 1-800-252-2439. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Texas Consumer Assistance Program at 1-800-252-3439.

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): Dine'ehgo shika at'ohwol ninisingo, kwijigo 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	\$2,500
■ Specialist copayment	\$45
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$30
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,090

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$45
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$45
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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 연락해주시요.
Arabic:	إذا كان لديك أو لدى شخص تساعدك أسئلة حول أي عرض من عروض Ambetter Health، ولم تكن تجيد التحدث باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت تعاني، أنت أو أي شخص تساعدك، 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).
Urdu:	اگر آپ کو، یا جس کی آپ مدد کر رہے ہیں اس کو Ambetter Health کی کسی بھی پیشکش کے بارے میں سوالات درپیش ہیں، اور 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 بروقت معاون امداد اور خدمات حاصل کرنے کا حق ہے۔ ترجمہ یا معاون خدمات حاصل کرنے کے لیے، براہ کرم 1-833-543-3145 (TTY 711) پر ممبر سروسز سے رابطہ کریں۔
Tagalog:	Kung ikaw, o ang iyong tinutulongan, 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 tinutulongan, 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).
Hindi:	अगर आपको या आपके द्वारा मदद किए जा रहे किसी व्यक्ति को Ambetter Health की किसी भी पेशकश के बारे में कोई सवाल है और आप अंग्रेजी में कुशल नहीं हैं, तो आपको अपनी भाषा में बिना किसी कीमत के और समय पर मदद और जानकारी पाने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-833-543-3145 (TTY 711) पर सदस्य सेवाएं से संपर्क करें.
Persian:	اگر شما یا فردی که دارید به او کمک می کنید، سؤالی درباره هر یک از پیشنهادهای Ambetter Health دارید، و انگلیسی نمی دانید، 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 می کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می کند، حق دارید کمک ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-833-543-3145 (TTY 711) تماس بگیرید.
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).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter Health દ્વારા જે પ્રદાન કરવામાં આવે તે વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-833-543-3145 (TTY 711) પર સભ્યની સેવાઓનો સંપર્ક કરો.
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).
Japanese:	ご自身やあなたが介護している他の人が、Ambetter Healthが提供する医療保険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、1-833-543-3145 (TTY 711)のメンバーサービスにご連絡ください。
Laotian:	ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບສິ່ງທີ່ Ambetter Health ນອບໃຫ້ 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).