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/en/ks/2027-brochures.html, or call 1-844-518-9505 (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 1-844-518-9505 (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: $8,600 individual / $17,200 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/en/ks/findadoc or call 1-844-518-9505 (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	$30 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	Specialist visit	$60 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)	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.
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic drugs	Tier 1a - Preferred Generic Retail: $15 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 34 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.

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)	
coverage is available at https://ambetterhealth.com/en/ks/2027formulary		Tier 1b - Generic Retail: $15 Copay / prescription; deductible does not apply		
	Preferred brand drugs	Tier 2 - Retail: $30 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 34 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: $60 Copay / prescription; deductible does not apply	Not covered	
	Specialty drugs	Tier 4 - Retail: $250 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 34 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	25% Coinsurance	25% Coinsurance	None
	Emergency medical transportation	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, you may be subject to balance billing.
	Urgent care	$45 Copay / visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	25% Coinsurance	Not covered	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)	
				No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 Copay / visit; deductible does not apply; Other Outpatient Services: No charge; deductible does not apply	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	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$30 Copay / visit; deductible does not apply	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% 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	25% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	Not covered	Prior authorization may be required. Note: Includes educational visits - limited to 3 per year.
	Rehabilitation services	Outpatient: $30 Copay / visit; deductible does not apply	Not covered	Outpatient: Prior authorization may be required. No limit per therapy for occupational and physical therapy; speech therapy limited to 1 service per day, up to a

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)	
		Inpatient: 25% Coinsurance		maximum benefit of 90 daily services per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Unlimited coverage includes speech, occupational and physical therapy.
	Habilitation services	Outpatient: $30 Copay / visit; deductible does not apply Inpatient: 25% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Unlimited coverage includes speech, occupational and physical therapy. Inpatient: Prior authorization may be required. Unlimited coverage includes speech, occupational and physical therapy.
	Skilled nursing care	Not covered	Not covered	Not Covered.
	Durable medical equipment	25% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	25% 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	Eye exams are covered as appropriate. The first visit in a benefit year is covered at 100% as preventive care. Additional visits beyond the initial exam will be covered as specialist visits.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 3 sets of lenses and frames 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 in cases when the life of the member is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Skilled nursing care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.) • Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)	• Private-duty nursing (On home and outpatient basis only (inpatient excluded)) • Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.)	• Routine foot care • Spinal manipulation

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 Sunflower Health Plan at 1-844-518-9505 (TTY 711); Kansas Department of Insurance, 1300 SW Arrowhead Road, Topeka, KS, 66604, Phone: 1-800-432-2484; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Kansas Consumer Assistance Program at 1-800-432-2484; 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: Kansas Department of Insurance, 1300 SW Arrowhead Road, Topeka, KS, 66604, Phone: 1-800-432-2484. Additionally, a consumer assistance program can help you file your appeal. Contact Kansas Consumer Assistance Program at 1-800-432-2484.

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 1-844-518-9505 (TTY 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-9505 (TTY 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-518-9505 (TTY 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-518-9505 (TTY 711).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-518-9505 (TTY 711) uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-518-9505 (TTY 711).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-518-9505 (TTY 711).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-518-9505 (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	$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*	$2,500
Copayments	$40
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,500**

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	$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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$900
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$2,500
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*	$2,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English:
If you, or someone you are helping, have questions about Ambetter from Sunflower Health Plan, 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 1-844-518-9505 (TTY 711).

Spanish:
Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY 711).

Vietnamese:
Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY 711).

Chinese:
如果您或您正在協助的對象對 Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY 711)。

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunflower Health Plan hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-844-518-9505 (TTY 711).

Korean:
귀하 또는 귀하의 도움을 받는 분이 Ambetter from Sunflower Health Plan에 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 1-844-518-9505 (TTY 711)번으로 가입자 서비스부에 연락해주십시오.

Laotian:
ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter from Sunflower Health Plan, 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 1-844-518-9505 (TTY 711).

Arabic:
إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunflower Health Plan، 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 بـخدمات الأعضاء على 1-844-518-9505 (TTY 711).

Tagalog:
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Sunflower Health Plan, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o pannikin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag ugnayan sa Mga Serbisyo para sa Miyembro sa 1-844-518-9505 (TTY 711).

Burmese:

အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် Ambetter from Sunflower Health Plan အကြောင်းနှင့် 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 1-844-518-9505 (TTY 711) ရှိ အဖွဲ့ဝင် ဝန်ဆောင်မှုများကို ဆက်သွယ်ပါ။

French:

Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY 711).

Japanese:

ご自身やあなたが介護している他の人が、Ambetter from Sunflower Health Plan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、1-844-518-9505 (TTY 711)のメンバーサービスにご連絡ください。

Russian:

Если у вас или у лица, которому вы помогаете, возникли какие либо вопросы о программе страхования Ambetter from Sunflower Health Plan, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-844-518-9505 (TTY 711).

Hmong:

Yog tias koj, los sis ib tug neeg twg uas koj tab tom muab kev pab, muaj cov lus nug hais txog Ambetter from Sunflower Health Plan, thiab tsis paub lus Askiv zoo heev, koj muaj cai tau txais kev pab thiab tej ntaub ntawv qhia paub ua koj hom lus yam tsis tau them dab tsi li thiab kom tau raws sij hawm. 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 1-844-518-9505 (TTY 711).

Persian:

اگر شما یا فردی که دارید به او کمک می‌کنید، سؤالی درباره Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY 711) تماس بگیرید.

Swahili:

Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter from Sunflower Health Plan, na huelewi Kiingereza vizuri, una haki ya kupata usaidizi na maelezo kwa lugha yako bila kulipa ada yoyote na kwa wakati ufaao. Ikiwa wewe, au mtu unayemsaidia, ana tatizo la kusikia na/au la kuona ambalo linazuia mawasiliano, una haki ya kupata usaidizi na huduma za ziada bila kulipa ada yoyote na kwa wakati unaofaa. Ili kupata huduma za tafsiri au za ziada, tafadhali wasiliana na Huduma kwa Wanachama 1-844-518-9505 (TTY 711).