**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/oh/2027-brochures.html or call 1-877-687-1189 (TTY 1-877-941-9236). 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 1-877-687-1189 (TTY 1-877-941-9236) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,200 individual / $2,400 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: $9,150 individual / $18,300 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/oh/findadoc or call 1-877-687- | 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | 1189 (TTY 1-877-941-9236) for a list of network providers. | network provider might use an out-of-network provider for some services (such as lab 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 | $25 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 | $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) | 30% Coinsurance for laboratory & professional services<br>30% Coinsurance for x-ray & diagnostic imaging<br>30% 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.<br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. |
| | Imaging (CT/PET scans, MRIs) | 30% 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **https://ambetterhealth.com/en/oh/2027formulary** | Generic drugs | Tier 1a - Preferred Generic Retail: $3 Copay / prescription; deductible does not apply<br>Tier 1b - Generic Retail: $15 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. |
| | Preferred brand drugs | Tier 2 - Retail: $40 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: 45% 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) | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need immediate medical attention** | Emergency room care | 30% Coinsurance | 30% Coinsurance | None |
| | Emergency medical transportation | 30% Coinsurance | 30% Coinsurance | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. |
| | Urgent care | $60 Copay / visit; deductible does not apply | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 30% 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: $25 Copay / visit; deductible does not apply;<br>Other Outpatient Services: 30% 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 | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you are pregnant** | Office visits | $25 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 | 30% 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 | 30% Coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% Coinsurance | Not covered | Prior authorization may be required. Limited to 100 visits per year. |
| | Rehabilitation services | Outpatient: $25 Copay / visit; deductible does not apply<br>Inpatient: 30% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Limited to 20 visits each (including speech, occupational, and physical therapy), cardiac limited to 36 visits and pulmonary limited to 20 visits per year. Services may be used for intensive day rehabilitation. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.<br>Inpatient: Prior authorization may be required. |

| 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) | |
| | | | | Limited to 60 days per year (including speech, occupational and physical therapy). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. |
| | Habilitation services | Outpatient: $25 Copay / visit; deductible does not apply<br>Inpatient: 30% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Unlimited coverage includes speech, occupational and physical therapy. Inpatient: Prior authorization may be required. Limited to 60 days per year (including speech, occupational and physical therapy). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. |
| | Skilled nursing care | 30% Coinsurance | Not covered | Prior authorization may be required. Limited to 90 days per year. |
| | Durable medical equipment | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 30% 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 exam 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 in cases of rape, incest, or when the life of the member is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- 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.) | | |
|---|---|---|
| • Chiropractic care (Limited to 12 visits per year)<br>• Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)<br>• Hearing aids (Limited to 1 hearing aid per hearing impaired ear up to $2,500 every 48 months for members aged 21 and under.) | • Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)<br>• Private-duty nursing (Limited to 90 visits per year) | • Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.)<br>• Routine foot care |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Buckeye Health Plan at 1-877-687-1189 (TTY 1-877-941-9236); Ohio Department of Insurance, 50 West Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, Phone:1-800-686-1526; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or Office of Personnel Management Multi-State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Ohio Department of Insurance, 50 West Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, Phone:1-800-686-1526.

**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 1-877-687-1189 (TTY 1-877-941-9236).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1189 (TTY 1-877-941-9236).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-687-1189 (TTY 1-877-941-9236).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-687-1189 (TTY 1-877-941-9236).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-687-1189 (TTY 1-877-941-9236) uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-687-1189 (TTY 1-877-941-9236).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-687-1189 (TTY 1-877-941-9236).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-687-1189 (TTY 1-877-941-9236).

*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 | $1,200 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $1,200 |
| Copayments | $40 |
| Coinsurance | $2,600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,900** |

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

| | |
|---|---|
| The plan's overall deductible | $1,200 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $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 | $1,200 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $1,200 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

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 Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**Spanish:**

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**Haitian Creole:**

Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from Buckeye Health Plan, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-877-687-1189 (TTY 1-877-941-9236).

**Ukrainian:**

Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Buckeye Health Plan, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв'яжіться зі Службою обслуговування учасників за номером 1-877-687-1189 (TTY 1-877-941-9236).

**Nepali:**

यदि तपाईं स्वयं वा तपाईंले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from Buckeye Health Plan सँग सम्बन्धित प्रश्नहरू छन् र तपाईं दुवै अंग्रेजीमा निपुण हुनुहुन्न भने तपाईंसँग निःशुल्क रूपमा र समयमै आफ्नो भाषामा मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। यदि तपाईं वा तपाईंले मद्दत गरिरहनुभएको व्यक्तिसँग सञ्चारमा बाधा पुऱ्याउने श्रवण र/वा दृश्यसम्बन्धी समस्या छ भने तपाईंसँग निःशुल्क रूपमा र समयमै सहायक उपकरण र सेवाहरू प्राप्त गर्ने अधिकार छ। अनुवाद वा सहायक सेवाहरू प्राप्त गर्न कृपया 1-877-687-1189 (TTY 1-877-941-9236) मा सदस्य सेवाहरू लाई सम्पर्क गर्नुहोस्।

**Arabic:**

إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Buckeye 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 بـ خدمات الأعضاء على 1-877-687-1189 (TTY 1-877-941-9236).

**Somali:**

Haddii adiga, ama qof aad caawinaysaa, uu qabo su'aalo ku saabsan Ambetter from Buckeye Health Plan, oo aanu si wanaagsan ugu hadal Ingiriisiga, waxaad xaq u leedahay inaad hesho caawimo iyo macluumaad ah luqaddaada oo aan kharash ahayn iyo wakhti habboon. Haddii adiga, ama qof aad caawinayso, aad qabtaan xaalado maqalka ah iyo/ama araga ah oo xanibta wada xidhiidhka, waxaad xaq u leedahay inaad hesho kaalmada wada xidhiidhka iyo adeegyada oo aan kharash kugu joogin qaab wakhti habboon ah. Si aad u hesho turjumaad iyo adeegyada kaalmada wada xidhiidhka, fadlan la xidhiidh Adeegyada Xubinta lambarka 1-877-687-1189 (TTY 1-877-941-9236).

**Russian:**

Если у вас или у лица, которому вы помогаете, возникли какие либо вопросы о программе страхования Ambetter from Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**Swahili:**

Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter from Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**French:**

Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**Kinyarwanda:**

Niba wowe, cyangwa undi muntu uri gufasha, mufite ibyo mwibaza kuri Ambetter from Buckeye Health Plan, ndetse mukaba mutazi neza Icyongereza, Ufite uburenganzira bwo guhabwa ubufasha n'amakuru mu rurimi rwawe nta kiguzi utanze ndetse ku gihe. Niba wowe, cyangwa undi muntu uri gufasha, afite uburwayi mu kumva na/cyangwa kureba bubangamiye itumanaho, ufite uburenganzira bwo guhabwa inyunganirangingo mu kumva na serivisi bijyanye nta kiguzi utanze ndetse ku gihe. Kugira ngo uhabwe ubusemuzi cyangwa serivisi z'inyunganirangingo mu kumva, turagusabye vugana na Serivisi zishinzwe Umunyamuryango kuri 1-877-687-1189 (TTY 1-877-941-9236).

**Uzbek:**

Sizda yoki siz yordam berayotgan kimdirda Ambetter from Buckeye Health Plan haqida savollar tug‘ilsa va ingliz tilini yaxshi bilmasangiz, o‘z tilingizda bepul va o‘z vaqtida yordam hamda axborot olish huquqiga egasiz. Sizda yoki siz yordam berayotgan kimdirda muloqotga xalal beradigan eshitish va/yoki ko‘rish muammolari bo‘lsa, qo‘shimcha yordam va xizmatlardan bepul va o‘z vaqtida foydalanish huquqiga egasiz. Tarjima yoki qo‘shimcha xizmatlardan foydalanish uchun Mijozlarga xizmat bo‘limiga murojaat qiling 1-877-687-1189 (TTY 1-877-941-9236).

**Pashtu:**

که تاسو، یا هغه څوک چې تاسو ورسره مرسته کوئ، د Ambetter from Buckeye Health Plan په اړه پوښتنې لرئ، او په انګلیسي ژبه کې مهارت نه لرې نو تاسو حق لرئ چې په خپله ژبه کې وړیا او پر وخت مرسته او معلومات ترلاسه کړئ. که تاسو, یا هغه څوک چې تاسو ورسره مرسته کوئ، د اوریدو او/یا د لیدلو ستونزه لرئ چې د اړیکو مخه نیسي چې تاسو حق لرئ چې مرستندویه مرستې او خدمات په وړیا توګه او په وخت سره ترلاسه کړئ. د ژباړې یا مرستندویه خدماتو ترلاسه کولو لپاره، مهرباني وکړئ د غړو خدماتو سره د 1-877-687-1189 (TTY 1-877-941-9236) سره اړیکه ټینګه کړئ.

**Vietnamese:**

Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Buckeye 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 1-877-687-1189 (TTY 1-877-941-9236).

**Tigrinya:**

ባዕልኻ ወይ ንስኻ እትሕግዞ ሰብ ብዛዕባ ኣብ ትሕቲ Ambetter from Buckeye Health Plan ሕቶታት እንተልዮምኹም፣ ግን ከኣ ናይ ቋንቋ ኢንግሊሽ ብቕዓት እንድሕር ዝነድለኩም ኰይኑ፣ ሓገዝን ሓበሬታን ብቑንቋኹም፣ ብናጻን ኣብ ትኽክለኛ እዋንን ክትረኽቡ መሰል ኣለኩም። ባዕልኻ ወይ ንስኻ እትሕግዞ ሰብ ክትረዳዳኡ ዝዕንቅፍ ናይ ምስማዕ ወይ ምርኣይ ጸገም እንተልዩኩም፣ ብናጻን ኣብ ሰዓቱን መስምዒ/መርኣዪ ሓገዛትን ኣገልግሎታትን ክትረኽቡ መሰል ኣለኩም። ናይ ትርጉም ወይድማ መስምዕዒ/መርኣዪ ሓገዛት ንምርካብ፣ በጃኻ ምስ ናይ ኣባላት ኣገልግሎታት ብ 1-877-687-1189 (TTY 1-877-941-9236) ተራኽብ።

**Dari:**

اگر شما یا فردی که به او کمک می‌کنید درباره Ambetter from Buckeye Health Plan سوالات دارید و به زبان انگلیسی مسلط نیستید، حق دارید بصورت رایگان و در زمان مناسب، کمک و معلومات را به زبان خود دریافت کنید. اگر شما یا فردی که به او کمک می‌کنید دچار مشکل شنوایی و/یا بینایی هستید که مانع از برقراری ارتباط می‌شود، این حق را دارید که وسایل و خدمات کمکی را بصورت رایگان و در زمان مناسب دریافت کنید. برای دریافت خدمات ترجمه یا خدمات کمکی، لطفاً با خدمات اعضا به شماره 1-877-687-1189 (TTY 1-877-941-9236) تماس بگیرید.