**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/sc/2027-brochures.html or call 1-833-270-5443 (Relay 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 1-833-270-5443 (Relay 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $6,400 individual / $12,800 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: $10,300 individual / $20,600 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/sc/findadoc or call 1-833-270- | 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: |
|---|---|---|
| | 5443 (Relay 711) 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 | $40 Copay / visit; deductible does not apply | Not covered | Covered No Limit. |
| | Specialist visit | $80 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) | 40% Coinsurance for laboratory & professional services<br>40% Coinsurance for x-ray & diagnostic imaging<br>40% 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) | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need drugs to treat your illness or** | Generic drugs | Tier 1a - Preferred Generic Retail: $20 Copay / | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **condition** More information about **prescription drug coverage** is available at **https://ambetterhealth.com/en/sc/2027formulary** | | prescription; deductible does not apply<br>Tier 1b - Generic Retail: $20 Copay / prescription; deductible does not apply | | 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: $80 Copay / prescription | Not covered | |
| | Specialty drugs | Tier 4 - Retail: $350 Copay / prescription | 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) | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need immediate medical attention** | Emergency room care | 40% Coinsurance | 40% Coinsurance | None |
| | Emergency medical transportation | 40% Coinsurance | 40% Coinsurance | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider, you may be subject to balance billing. |
| | Urgent care | $60 Copay / visit; deductible does not apply | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No |

| 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) | |
| | fees | | | Limit. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit: $40 Copay / visit; deductible does not apply;<br>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 | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you are pregnant** | Office visits | $40 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 | 40% 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 | 40% Coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 40% Coinsurance | Not covered | Prior authorization may be required. Limited to 60 visits per year. |
| | Rehabilitation services | Outpatient: $40 Copay / visit; deductible does not apply<br>Inpatient: 40% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Limited to 30 visits per year per therapy (occupational, physical and speech therapy); no limit applies for cardiac or pulmonary therapy. 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) | |
| | | | | Unlimited coverage includes speech, occupational and physical therapy. |
| | Habilitation services | Outpatient: $40 Copay / visit; deductible does not apply<br>Inpatient: 40% Coinsurance | Not covered | Outpatient: Prior authorization may be required. Limited to 30 visits per year per therapy (occupational, physical and speech therapy); no limit applies for cardiac or pulmonary therapy. 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. |
| | Skilled nursing care | 40% Coinsurance | Not covered | Prior authorization may be required. Limited to 60 days per year. |
| | Durable medical equipment | 40% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 40% 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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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<br>• Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.) | • Routine eye care (Adult-one visit, one frame, and one pair of lenses. Dollar allowances apply to hardware.) | • Routine foot care |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Absolute Total Care at 1-833-270-5443 (Relay 711); South Carolina Department of Insurance, 1201 Main Street, Columbia, SC, 29201, Phone: 1-803-737-6180; 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: South Carolina Department of Insurance, 1201 Main Street, Columbia, SC, 29201, Phone: 1-803-737-6180.

**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 1-833-270-5443 (Relay 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-270-5443 (Relay 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-270-5443 (Relay 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-270-5443 (Relay 711).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-270-5443 (Relay 711) uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-270-5443 (Relay 711).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-270-5443 (Relay 711).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-270-5443 (Relay 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 | $6,400 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $6,400 |
| Copayments | $50 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,910** |

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

| | |
|---|---|
| The plan's overall deductible | $6,400 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $1,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

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

| | |
|---|---|
| The plan's overall deductible | $6,400 |
| Specialist copayment | $80 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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 | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,500** |

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 Absolute Total Care, 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 1-833-270-5443 (Relay 711).

**Spanish:**

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).

**Vietnamese:**

Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).

**Portuguese:**

Se tiver dúvidas ou estiver a ajudar uma pessoa com dúvidas acerca do Ambetter from Absolute Total Care e não falar inglês, tem direito a obter ajuda e informações no seu idioma, sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem direito a receber equipamentos ou serviços de assistência, sem qualquer custo e de forma atempada. Para ter acesso a traduções ou a serviços de assistência, contacte os Serviços de Membros através do número 1-833-270-5443 (Relay 711).

**Chinese:**

如果您或您正在協助的對象對 Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711)。

**Russian:**

Если у вас или у лица, которому вы помогаете, возникли какие либо вопросы о программе страхования Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).

**Ukrainian:**

Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).

**Gujarati:**

જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711) પર સભ્યની સેવાઓનો સંપર્ક કરો.

**Tagalog:**

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).

**French:**

Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).

**Swahili:**

Ikiwa wewe, au mtu unayemsaidia, ana maswali kuhusu Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).

**German:**

Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711)

**Korean:**

귀하 또는 귀하의 도움을 받는 분이 Ambetter from Absolute Total Care에 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 1-833-270-5443 (Relay 711)번으로 가입자 서비스부에 연락해주십시오.

**Thai:**

หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Absolute Total Care และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่า ใช้จ่ายอย่างทันท่วงที หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เ ป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-270-5443 (Relay 711)

**Tamil:**

நீங்கள் அல்லது நீங்கள் உதவுகிற ஒருவருக்கு, Ambetter from Absolute Total Care பற்றி ஏதேனும் கேள்விகள் இருந்து, மேலும் ஆங்கிலத்தில் நிபுணத்துவம் இல்லாவிட்டால், உங்கள் மொழியில் உதவியும் தகவல்களும் இலவசமாகவும், தேவையான நேரத்தில் பெறும் உரிமை உங்களுக்கு உள்ளது. நீங்கள் அல்லது நீங்கள் உதவி செய்யும் ஒருவருக்கு, தொடர்புக்கு இடையூறாக இருக்கும் செவிப்புலன் மற்றும்/அல்லது பார்வை கோளாறு இருந்தால், துணை உதவிகள் மற்றும் சேவைகளை இலவசமாகவும் சரியான நேரத்திலும் பெற உங்களுக்கு உரிமை உண்டு. மொழிபெயர்ப்பு அல்லது துணை சேவைகளைப் பெற, தயவுசெய்து உறுப்பினர் சேவைகள் ஐ 1-833-270-5443 (Relay 711) என்ற எண்ணில் தொடர்பு கொள்ளவும்.

**Haitian Creole:**

Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).