



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://ambetter.coordinatedcarehealth.com/2022-brochures.html>, or call 1-877-687-1197 (TTY/TDD 1-877-941-9238). 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 1-877-687-1197 (TTY/TDD 1-877-941-9238) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 individual / \$0 family.	See the Common Medical Events chart below for your cost for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes, except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes, \$3,800 individual / \$7,600 family for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$8,700 individual / \$17,400 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, costs for non-covered services, and services provided by <u>out-of-network providers</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://ambetter.coordinatedcarehealth.com/findadoc or call 1-877-687-1197 (TTY/TDD 1-877-941-9238) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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 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	\$45 Copay / visit	Not covered	Unlimited Virtual Care Visits covered at No Charge, providers covered in full.
	Specialist visit	\$115 Copay / visit	Not covered	Covered No Limit.
	Preventive care/screening/immunization	No charge	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)	\$60 Copay / test for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	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. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	50% 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://ambetter.coordinatedcarehealth.com/2022formulary .	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 Copay / prescription Generic Retail: \$35 Copay / prescription	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: \$195 Copay / prescription	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 (Tier 3)	Retail: \$250 Copay / prescription; subject to Rx drug deductible	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. \$3,800 individual / \$7,600 family Rx drug deductible for non-preferred brand and specialty drugs .
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance ; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. \$3,800 individual / \$7,600 family Rx drug deductible for non-preferred brand and specialty drugs .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	\$2,500 Copay / visit (\$1,250 Copay / visit for facility; \$1,250 Copay / visit for physician fee)	\$2,500 Copay / visit; deductible does not apply (\$1,250 Copay / visit; deductible does not apply for facility; \$1,250 Copay	Covered No Limit. For emergency services in Washington state and out-of-state, only in- network cost sharing amounts are applicable; providers /hospitals aren't permitted to balance bill members - despite network

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)	
			/ ; deductible does not apply for physician fee)	status. (See note on balance billing above this chart.)
	Emergency medical transportation	50% Coinsurance	50% Coinsurance ; deductible does not apply	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	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,000 Copay per Day	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$45 Copay /Office Visit; 50% Coinsurance for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	\$3,000 Copay per Day	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$45 Copay / visit	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	No charge	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
	Childbirth/delivery facility services	\$3,000 Copay per Day	Not 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)	
				services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 130 visits per year.
	Rehabilitation services	Outpatient: 50% Coinsurance Inpatient: \$3,000 Copay per Day	Not covered	Outpatient: Prior authorization may be required after 6th visit. Limited to 25 outpatient visits per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 30 inpatient days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Not covered	Outpatient: Prior authorization may be required after 6th visit. Limited to 25 outpatient visits per year. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 30 inpatient days per year. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	\$3,000 Copay per Day	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	50% 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)	
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 14 days per lifetime for respite care covered in conjunction with hospice services .
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 1 item per year. Limited to one frame and one pair (two lenses) per calendar year or contacts in lieu of glasses.
	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 .)			
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery Dental care 	<ul style="list-style-type: none"> Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.) Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)			
<ul style="list-style-type: none"> Abortion Acupuncture (Limited to 12 visits per year. Note: visits are unlimited for chemical dependency treatment.) Chiropractic care (Limited to 10 visits per year.) 	<ul style="list-style-type: none"> Hearing aids (Covered for cochlear implants and bone anchored hearing aids (BAHA) only.) Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility.) 	<ul style="list-style-type: none"> Routine eye care (Adult-one visit & one item per year. Dollar limits apply.) Routine foot care (Coverage is limited to diabetes care only.) 	

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 Coordinated Care at 1-877-687-1197 (TTY/TDD 1-877-941-9238); Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080. 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: Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080.

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 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 1-877-687-1197 (TTY/TDD 1-877-941-9238).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1197 (TTY/TDD 1-877-941-9238).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-687-1197 (TTY/TDD 1-877-941-9238).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-687-1197 (TTY/TDD 1-877-941-9238).

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$115	■ Specialist copayment	\$115	■ Specialist copayment	\$115
■ Hospital (facility) copayment	\$3,000	■ Hospital (facility) copayment	\$3,000	■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%	■ Other coinsurance	50%	■ Other coinsurance	50%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles *	\$10	Deductibles *	\$3,500	Deductibles *	\$10
Copayments	\$3,600	Copayments	\$700	Copayments	\$1,100
Coinsurance	\$200	Coinsurance	\$400	Coinsurance	\$800
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$3,870	The total Joe would pay is	\$4,620	The total Mia would pay is	\$1,910

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Statement of Non-Discrimination

Ambetter from Coordinated Care Corporation complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, gender identity or sexual identity. Ambetter from Coordinated Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, gender identity or sexual orientation.

Ambetter from Coordinated Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Ambetter from Coordinated Care at 1-877-687-1197 (TTY/TDD 1-877-941-9238).

If you believe that Ambetter from Coordinated Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, gender identity or sexual orientation, you can file a grievance with: Grievances Coordinator, Coordinated Care, 1145 Broadway, Suite 300, Tacoma, WA 98402, 1-877-687-1197 (TTY/TDD 1-877-941-9238), Fax 1-855-218-0588. You can file a grievance by mail, fax, or email WAqualitydept@centene.com. If you need help filing a grievance, Ambetter from Coordinated Care is available to help you. You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Coordinated Care Corporation, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Coordinated Care Corporation 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1197 (TTY/TDD 1-877-941-9238)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Coordinated Care Corporation, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Coordinated Care Corporation 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1197 (TTY/TDD 1-877-941-9238)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Coordinated Care Corporation вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care Corporation, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Coordinated Care Corporation ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Mon-Khmer, Cambodian:	ប្រសិនបើលោកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានបញ្ហាអំពី Ambetter from Coordinated Care Corporation អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសាខ្មែរដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែភាសា 1-877-687-1197 (TTY/TDD 1-877-941-9238)
Japanese:	Ambetter from Coordinated Care Corporation について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1197 (TTY/TDD 1-877-941-9238) までお電話ください。
Amharic:	እርስዎ ወይም እርስዎ የሚርዱት ሰው ስለ Ambetter from Coordinated Care Corporation ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ አስተርጓሚ ለማነጋገር በ 1-877-687-1197 (TTY/TDD 1-877-941-9238) ይደውሉ፤
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Coordinated Care Corporation (Kuununsaa Qindeeffamaa) irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu, 1-877-687-1197 irra bilbilli (TTY/TDD 1-877-941-9238).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Coordinated Care Corporation، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Ambetter from Coordinated Care Corporation ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ. ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-687-1197 (TTY/TDD 1-877-941-9238) 'ਤੇ ਕਾਲ ਕਰੋ।
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Coordinated Care Corporation hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1197 (TTY/TDD 1-877-941-9238) an.
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Coordinated Care Corporation, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນ ຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໃຫ້ຫາ 1-877-687-1197 (TTY/TDD 1-877-941-9238).