





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, 1-844-800-4693 and [www.senderohealth.com](http://www.senderohealth.com). 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-844-800-4693 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$4,000 /Individual or \$8,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,500/Individual or \$13,000/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://senderohealth.com/idealcareeng/providers.html">https://senderohealth.com/idealcareeng/providers.html</a> or call 1-844-800-4693 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /office visit <a href="#">Deductible</a> does not apply.	Not covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /office visit	Not covered	A <a href="#">referral</a> must be obtained from your <a href="#">primary care physician</a> before you see a <a href="#">specialist</a> . (OB/GYN and Behavioral/Substance abuse <a href="#">providers</a> do not require a <a href="#">referral</a> ). <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copay</a>	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://senderohealth.com/idealcareeng/formulary.html">https://senderohealth.com/idealcareeng/formulary.html</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply.	Not covered	Covers up to a 30-day supply. Certain preventive drugs are covered with no <a href="#">copay</a> . Oral & injectable fertility drugs are excluded. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	Preferred brand drugs	\$40 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply.	Not covered	
	Non-preferred brand drugs	\$80 <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> /prescription	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.senderohealth.com](http://www.senderohealth.com).

 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 <a href="#">copay</a> /visit	\$350 <a href="#">copay</a> /visit	<a href="#">Emergency room services copay</a> is waived if admitted and inpatient benefits are applied. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	<a href="#">Emergency medical transportation</a>	\$350 <a href="#">copay</a> /transport	\$350 <a href="#">copay</a> /transport	<a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <a href="#">copay</a> /stay	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <a href="#">coinsurance</a> /per visit	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	Inpatient services	\$350 <a href="#">copay</a> /stay	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /office visit	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a>

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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)	
		<a href="#">Deductible</a> does not apply.		<a href="#">services</a> . <a href="#">Copay</a> per initial visit and delivery. No charge for subsequent prenatal visits with the same <a href="#">provider</a> or <a href="#">provider</a> group per pregnancy. Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">copay</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	\$350 <a href="#">copay</a> /per delivery	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	Not covered	Limited to 60 visits per year. <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Rehabilitation services</a>	\$65 <a href="#">copay</a> /visit	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a> /visit	Not covered	<a href="#">Habilitation Services</a> include: Autism services and the benchmark <a href="#">plan</a> does not impose age or maximums on autism coverage. Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
	<a href="#">Skilled nursing care</a>	\$300 <a href="#">copay</a> /stay	Not covered	Limited to 25 visits per year. <a href="#">Preauthorization</a> is required. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment. <a href="#">Copayment</a> applies after <a href="#">deductible</a> has been met.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> /equipment	Not covered	Certain services may require <a href="#">preauthorization</a> . If <a href="#">preauthorization</a> is not obtained you may be responsible for

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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)	
				payment.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required for services. If <a href="#">preauthorization</a> is not obtained you may be responsible for payment.
If your child needs dental or eye care	Children's eye exam	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	Limited to one (1) visit per year.
	Children's glasses	20% <a href="#">coinsurance</a>	Not covered	Limited to contact lenses or 1 pair of glasses (frames and lenses) per calendar year for members 0-21 years of age. Limited to the end of the <a href="#">plan</a> year in which age 21 is reached.
	Children's dental check-up	20% <a href="#">coinsurance</a>	Not covered	Limited to the last day of the month in which member turns 19.

#### 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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Abortions (endangerment of life of the mother, rape, or incest)
- Chiropractic care, limited to 35 visits per year.
- Hearing aids are limited to 1 per ear every 3 years.
- Infertility treatment is limited to diagnostic services only. Treatment to correct the infertility condition and services such as in vitro fertilization and artificial insemination are excluded from coverage.
- Private-duty nursing if [medically necessary](#).
- Routine foot care is limited to foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.senderohealth.com](http://www.senderohealth.com).

**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:

- IdealCare by Sendero Health Plans 1-844-800-4693 or visit [www.senderohealth.com](http://www.senderohealth.com)
- Texas Department of Insurance: 1-800-578-4677 or visit <http://www.tdi.texas.gov/index.html>
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>.
- Healthcare.gov <http://www.HealthCare.gov> or call 1-800-318-2596 OR state [health insurance marketplace](#) or SHOP.

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](http://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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- Texas Department of Insurance 1-800-578-4677 or visit <http://www.tdi.texas.gov/index.html>

#### **Does this [plan](#) provide [Minimum Essential Coverage](#)? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### **Does this [plan](#) meet the [Minimum Value Standards](#)? Yes**

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 1-844-800-4693.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-800-4693.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-800-4693.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-800-4693.

————— *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 [network provider](#) pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$350

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$3,400
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,400</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,430</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$350
■ Other <a href="#">copayment</a>	\$350

This EXAMPLE event includes services like:

[Emergency Room Care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$1,470
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,880</b>

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

## NONDISCRIMINATION AND ACCESSIBILITY

IdealCare by Sendero Health Plans, Inc. (IdealCare) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IdealCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IdealCare 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 IdealCare.

If you believe that IdealCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

IdealCare by Sendero Health Plans, Attn: Member Advocate, 2028 E. Ben White Blvd. Ste. 400, Austin, TX 78741, Telephone: 1-844-800-4693, TTY: 711, Fax: 512-901-9724, [Complaints@senderohealth.com](mailto:Complaints@senderohealth.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, IdealCare Customer Service 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



1. Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sendero Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-800-4693.
2. Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sendero Health Plans 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 1-844-800-4693.
3. Chinese	如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Sendero Health Plans, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-800-4693.
4. Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sendero Health Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-800-4693 로 전화하십시오.
5. Arabic	لا ح لوص ف ي لاقح ف يدل ك ، Sendero Health Plans ب خ صوص أ س ئ ةل ت ه دعاس صخش ل ند وأ ل يدك ك نانا تالص م مجرت عم ل ل نذحت. تك ل ةف يا ة نود نم ب ل غ كت لا يرورض ة. لاو م ع تامول لام ة دعاس ع بل 1-844-800-4693 ب
6. Urdu	ک و نود نو پات و م نی، ب ے را ک ے Sendero Health Plans ے ل اوس ک و نود نو پا روا ہ نی ہر ے ے ددم ک و ک یس پا گار 1-844-800-4693 ل ے ی، ک ے ک نر ے ب تا ے س ت نامجر ہ ے قح ک اک نر ے اح ل ص م لاع تامو روا ددم م تف م نی بز نا پائین ک یر س ف نو
7. Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sendero Health Plans may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-800-4693.
8. French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Sendero Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-800-4693.
9. Hindi	यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Sendero Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में माफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी धुभाषए से बात करने के धाए , 1-844-800-4693पर कॉधु करें।

10. Persian	که یه براد دار یان قحب اش ديداش مت، Sendero Health Plans دروم رد لاوس، م ي کن دي ک کم و اب ه اش که ه ک ی س ي ا امش، گار ن يام دي اح لص ت سام 1-844-800-4693 ن يام دي يرد ف ا ت يار ناگ روط ب ه ار دوخ بز نا ب ه تاعل اط او ک کم
11. German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Sendero Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-800-4693 an.
12. Gujarati	જો તમે અથવા તમે કોઇને મદદ કરી રહો છો તેમ જ કોઇને Sendero Health Plans વિશે પ્રશ્નો ઊભી રાખી તો તમને મદદ અને મહત્વની માહિતી મેળવવાનો અવકાશ છે. તે અર્થઘટન તમને મદદ કરી શકે છે. દા.લ. વધુ માહિતી માટે, આ 1-844-800-4693 પર કોલ કરો.
13. Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sendero Health Plans то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-800-4693.
14. Japanese	ご本人様、またはお客様の身の回りの方でもSendero Health Plansについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-800-4693までお電話ください。
15. Laotian	ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ອຳນາດກ່ຽວກັບ Sendero Health Plans ທ່ານມີ ສິດທິ ຈຳນວນໜຶ່ງ ທີ່ທ່ານສາມາດຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນຂ່າວສານທີ່ ບໍ່ມີ ພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-844-800-4693.