# Ambetter from Sunflower Health Plan:
# Ambetter Secure Care 5 (2021) + Vision + Adult Dental

Coverage for: Individual/Family| Plan Type: HMO

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.SunflowerHealthPlan.com/2021-brochures.html, or call 1-844-518-9505 (TTY/TDD 1-844-546-9713). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-844-518-9505 (TTY/TDD 1-844-546-9713) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $1,450 individual / $2,900 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 office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your deductible. | 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: $6,300 individual / $12,600 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, 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 Find a Provider or call 1-844-518-9505 (TTY/TDD 1-844-546-9713) for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance |

| | | |
|---|---|---|
| | | billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| 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 | $15 Copay / visit; deductible does not apply | Not covered | Virtual Visits from Ambetter Health covered at $0, providers covered in full, deductible does not apply. |
| | Specialist visit | $35 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) | $15 Copay / test for laboratory outpatient & professional services (deductible does not apply); 20% Coinsurance for x-ray and diagnostic imaging | Not covered | Prior authorization may be required. Covered No Limit. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details. |
| | Imaging (CT/PET scans, MRIs) | 20% 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<br>More information about prescription drug coverage is available at Preferred Drug List. | Generic drugs (Tier 1) | Retail: $15 Copay / prescription; deductible does not apply | Not covered | 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: $30 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 (Tier 3) | Retail: 30% Coinsurance | Not covered | |
| | Specialty drugs (Tier 4) | Retail: 30% 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) | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | 20% Coinsurance | 20% Coinsurance | -----None----- |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | -----None----- |
| | Urgent care | $35 Copay / visit; deductible does not apply | Not covered | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 20% 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 | $15 Copay / Office Visit (deductible does not apply); 20% Coinsurance for all 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 | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you are pregnant | Office visits | $15 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 | 20% 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 | 20% Coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | Not covered | Prior authorization may be required. Note: Limited to 3 educational visits per year. |
| | Rehabilitation services | 20% Coinsurance | Not covered | Prior authorization may be required. No limit per therapy for occupational and physical therapy; speech therapy limited to 1 service per day, up to a maximum benefit of 90 daily services per year. |
| | Habilitation services | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Skilled nursing care | Not covered | Not covered | 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) | |
| | Durable medical equipment | 20% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 20% 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 visit per year. |
| | Children's glasses | No charge; deductible does not apply | Not covered | Limited to 3 sets of lenses and frames per year. |
| | Children's dental check-up | Not covered | Not covered | -----None----- |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion (Unless the procedure is necessary to preserve the life of the mother)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- 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
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year.)
- Infertility treatment (Limited to diagnosis and treatment of cause of infertility.)
- Private-duty nursing
- Routine eye care (Adult-visit & one item per year. Dollar limits apply.)
- Routine foot care (Related to diabetes treatment)

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/EOC/2021/80065KS003.pdf.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Sunflower Health Plan at 1-844-518-9505 (TTY/TDD 1-844-546-9713); Kansas Insurance Department, 420 SW 9th Street Topeka, KS 66612, Phone No. 1-785-296-3071. 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Kansas Insurance Department, 420 SW 9th Street Topeka, KS 66612, Phone No. 1-785-296-3071. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-432-2484.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-518-9505 (TTY/TDD 1-844-546-9713).

*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 | $1,450 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $700 |
| Copayments | $300 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $2,560 |

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

| | |
|---|---|
| The plan's overall deductible | $1,450 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $700 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $1,520 |

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

| | |
|---|---|
| The plan's overall deductible | $1,450 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $700 |
| Copayments | $100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,000 |

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

| | |
|---|---|
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Sunflower Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Sunflower Health Plan, 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 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY/TDD 1-844-546-9713)。 |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunflower Health Plan 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 1-844-518-9505 (TTY/TDD 1-844-546-9713711) an. |
| **Korean:** | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Sunflower Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-518-9505 (TTY/TDD 1-844-546-9713) 로 전화하십시오. |
| **Laotian:** | ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Arkansas Health & Wellness of Arkansas, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunflower Health Plan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Tagalog:** | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Sunflower Health Plan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Burmese:** | သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် Ambetter from Sunflower Health Plan အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာ စကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-844-518-9505 (TTY/TDD 1-844-546-9713) ကို ဖုန်းဆက်ပါ။ |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunflower Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Japanese:** | Ambetter from Sunflower Health Plan 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、1-844-518-9505 (TTY/TDD 1-844-546-9713) までお電話ください。 |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Sunflower Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Hmong:** | Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter from Sunflower Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-518-9505 (TTY/TDD 1-844-546-9713). |
| **Persian:** | اگر شما، يا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Sunflower Health Plan داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-844-518-9505 (TTY/TDD 1-844-546-9713) تماس بگيريد. |
| **Swahili:** | Ikiwa wewe au mtu mwingine unayemsaidia, ana maswali kuhusu Ambetter from Sunflower Health Plan, una haki ya kupata usaidizi na taarifa kwa lugha yako bila malipo. Ili kuzungumza na mkalimani, piga simu 1-844-518-9505 (TTY/TDD 1-844-546-9713). |



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# Statement of Non-Discrimination

Ambetter from Sunflower Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Sunflower Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Sunflower Health Plan:

- 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 Sunflower Health Plan at 1-844-518-9505 (TTY/TDD 1-844-546-9713)

If you believe that Ambetter from Sunflower Health Plan 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: Ambetter from Sunflower Health Plan Appeals Unit, 8325 Lenexa Dr, Suite 410, Lenexa, KS 66214, 1-844-518-9505 (TTY/TDD 1-844-546-9713), Fax, 1-844-680-5805. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Sunflower Health Plan 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*.



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