Ambetter from Buckeye Health Plan:
Ambetter Essential Care 1 + Vision + Adult Dental

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.buckeyehealthplan.com/2022-brochures.html, or call 1-877-687-1189 (TTY/TDD 1-877-941-9236). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-877-687-1189 (TTY/TDD 1-877-941-9236) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $8,600 individual / $17,200 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, urgent care visits, children's eye exam and glasses, and generic 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: $8,600 individual / $17,200 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 https://ambetter.buckeyehealthplan.com/findadoc or call 1-877-687-1189 (TTY/TDD 1-877-941-9236) 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No charge	No charge	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply. Cost sharing waived at non-IHCP with IHCP referral.
	Specialist visit	No charge	No charge	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	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. Cost sharing waived at non-IHCP with IHCP referral.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge for laboratory & professional services No charge for x-ray & diagnostic imaging No charge 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. Cost sharing waived at non-IHCP with IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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.buckeyehealthplan.com/2022formulary**.	Generic drugs (Tier 1)	No charge	Preferred Generic Retail: $5 Copay / prescription; deductible does not apply Generic Retail: $25 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. Cost sharing waived at non-IHCP with IHCP referral.
	Preferred brand drugs (Tier 2)	No charge	Retail: No charge	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. Cost sharing waived at non-IHCP with IHCP referral.
	Non-preferred brand drugs (Tier 3)	No charge	Retail: No charge	Not covered	
	Specialty drugs (Tier 4)	No charge	Retail: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. Cost sharing waived at non-IHCP with IHCP referral.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Emergency medical transportation	No charge	No charge	No charge	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Urgent care	No charge	$60 Copay / visit; deductible does not apply	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge/Office Visit; No charge for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization). Cost sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	No charge	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). Cost sharing waived at non-IHCP with IHCP referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge	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 services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery facility services	No charge	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Prior authorization may be required. Limited to 100 visits per year. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	No charge	Not covered	Prior authorization may be required. Rehabilitation Therapy: Speech, Occupational and Physical Therapy limited to 20 visits each, Cardiac limited to 36 visits and Pulmonary limited to 20 visits per year. Services may be used for Intensive Day Rehabilitation. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Cost sharing waived at non-IHCP with IHCP referral.
	Habilitation services	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Skilled nursing care	No charge	No charge	Not covered	Prior authorization may be required. Limited to 90 days per year in a facility. Cost sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No charge	No charge; deductible does not apply	Not covered	Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No charge	No charge; deductible does not apply	Not covered	Limited to 1 item per year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	Not covered	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 mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- Hearing aids
- Infertility treatment (Not Covered. Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.)
- 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.
- Weight loss programs

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

- Chiropractic care (Limited to 12 visits per year)
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year.)
- Private-duty nursing (Limited to 90 visits per year)
- 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 Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236); Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526. 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.

*For more information about limitations and exceptions, see plan or policy document at https://api.centene.com/eoc/2022/41047OH003.pdf.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526.

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

Does this plan meet Minimum Value Standards? **Not Applicable**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-687-1189 (TTY/TDD 1-877-941-9236).

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$8,600
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	$8,600
Specialist [[SBCLABEL]]	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	$8,600
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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 Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye 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 1-877-687-1189 (TTY/TDD 1-877-941-9236)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye 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 1-877-687-1189 (TTY/TDD 1-877-941-9236) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Buckeye Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Buckeye Health Plan, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Buckeye Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1189 (TTY/TDD 1-877-941-9236).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Buckeye Health Plan gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu, 1-877-687-1189 irra bilbilli (TTY/TDD 1-877-941-9236).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1189 (TTY/TDD 1-877-941-9236)로 전화하십시오.
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Buckeye Health Plan, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1189 (TTY/TDD 1-877-941-9236).
Japanese:	Ambetter from Buckeye 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、1-877-687-1189 (TTY/TDD 1-877-941-9236) までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from Buckeye Health Plan, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-687-1189 (TTY/TDD (teksttelefoon) 1-877-941-9236) om met een tolk te spreken.
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Buckeye Health Plan ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Romanian:	Dacă dvs. sau o persoană pe care o asistați are întrebări despre Ambetter from Buckeye Health Plan, aveți dreptul să obțineți asistență și informații în limba dvs. în mod gratuit. Pentru a vorbi cu un interpret, apelați 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Statement of Non-Discrimination

Ambetter from Buckeye 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 Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Buckeye 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 Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1877-941-9236).

If you believe that Ambetter from Buckeye 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: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH 43219, 1-877-687-1189 (TTY/TDD 1-877-941-9236), Fax 1-866-719-5404. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Buckeye 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*.