




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://ambetterofoklahoma.com/2022-brochures.html>, or call 1-833-492-0679 (TTY 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-833-492-0679 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network providers</u> : \$1,500 Individual / \$3,000 Family. <u>Out-of-network providers</u> : \$4,500 Individual / \$9,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services, <u>urgent care</u> office visits, children's eye exam and glasses, generic and preferred brand drugs are covered before you meet your <u>deductible</u> .	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. For <u>out-of-network providers</u> : Not applicable Individual / Not applicable Family.	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, and health care this <u>plan</u> doesn't cover.	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://ambetterofoklahoma.com/findadoc or call 1-833-492-0679 (TTY 711) 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	\$40 Copay / visit; deductible does not apply	60% Coinsurance	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.
	Specialist visit	\$125 Copay / visit; deductible does not apply	60% Coinsurance	Covered No Limit.
	Preventive care/screening/immunization	No charge; deductible does not apply	60% Coinsurance ; deductible does not apply	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; deductible does not apply for laboratory & professional services	60% Coinsurance for laboratory & professional services	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.
		50% Coinsurance for x-ray & diagnostic imaging	60% Coinsurance for x-ray & diagnostic imaging	
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 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.

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)	
More information about prescription drug coverage is available at https://ambetterofoklahoma.com/2022formulary .		Generic Retail: \$35 Copay / prescription; deductible does not apply		Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: \$195 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: \$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	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	60% Coinsurance	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 (\$1,250 Copay / visit for facility; \$1,250 Copay / visit for physician fee)	Covered No Limit.
	Emergency medical transportation	50% Coinsurance	50% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport,

*For more information about limitations and exceptions, see [plan](#) or policy document at <https://api.centene.com/eoc/2022/62505OK012.pdf>.

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)	
				however, all non-emergent transport requires prior authorization.
	Urgent care	\$60 Copay / visit; deductible does not apply	60% Coinsurance ; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,000 Copay per Day	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge; deductible does not apply	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 Copay /Office Visit (deductible does not apply); 50% Coinsurance for other outpatient services	60% Coinsurance	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	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$40 Copay / visit; deductible does not apply	60% Coinsurance	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; deductible does not apply	60% Coinsurance	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	\$3,000 Copay per Day	60% Coinsurance	

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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 help recovering or have other special health needs	Home health care	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 30 visits per year.
	Rehabilitation services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Per year, a combined 25 visit limit applies for occupational, speech and physical therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Per year, a combined 25 visit limit applies for occupational, speech and physical therapy. 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	60% Coinsurance	Prior authorization may be required. Limited to 30 days per year.
	Durable medical equipment	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	50% Coinsurance	60% Coinsurance	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	Covered up to \$38.50; deductible does not apply
Children's glasses		No charge; deductible does not apply	Covered up to \$50; deductible does not apply	Limited to 1 item per year. Out-of-network provider frames or contacts covered up to \$50, see schedule for lens limit.
Children's dental check-up		Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services:

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

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment (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.
- 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.)

- Chiropractic care
- Hearing aids (Limited to 1 per ear every 4 years.)
- Private-duty nursing (Limited to 85 visits per year.)
- 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 of Oklahoma at 1-833-492-0679 (TTY 711); Oklahoma Insurance Department, 400 NE 50th St. Oklahoma City, OK 73105 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: Oklahoma Insurance Department, 400 NE 50th St. Oklahoma City, OK 73105 Additionally, a consumer assistance program can help you file your appeal. Contact 800-522-0071

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 1-833-492-0679 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-492-0679 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-492-0679 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-833-492-0679 (TTY 711).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



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

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$125
■ Hospital (facility) copayment	\$3,000
■ 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>)	
Total Example Cost	\$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles*	\$1,500
Copayments	\$3,600
Coinsurance	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,160

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$125
■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%
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>)	
Total Example Cost	\$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles*	\$4,300
Copayments	\$700
Coinsurance	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,020

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$125
■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%
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	\$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles*	\$1,500
Copayments	\$600
Coinsurance	\$400
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

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

Statement of Non-Discrimination

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

Ambetter of Oklahoma:

- 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 of Oklahoma at 1-833-492-0679 (TTY 711).

If you believe that Ambetter of Oklahoma 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 of Oklahoma, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-492-0679 (TTY 711), Fax 1-833-886-7956. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter of Oklahoma 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>.