



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.wellcareky.com/2022-brochures.html>, or call 1-833-705-2175 (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 1-833-705-2175 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 individual / \$0 family. | See the Common Medical Events chart below for your cost for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes, except for Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty drugs (Tier 4). | 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? | Yes, \$1,500 individual / \$3,000 family for prescription drug coverage . There are no other specific deductibles . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | For network providers : \$8,200 individual / \$16,400 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.wellcareky.com/findadoc or call 1-833-705-2175 (TTY 711) 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 | \$50 Copay / visit | Not covered | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full. |
| | Specialist visit | \$90 Copay / visit | Not covered | Covered No Limit. |
| | Preventive care/screening/immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$50 Copay / test for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service | Not covered | Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
| | Imaging (CT/PET scans, MRIs) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need drugs to treat your illness or condition | Generic drugs (Tier 1) | Preferred Generic Retail: \$5 Copay / prescription Generic Retail: \$30 Copay / prescription | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. |
| | Preferred brand drugs (Tier 2) | Retail: 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 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://ambetter.wellcare.com/2022formulary . | Non-preferred brand drugs (Tier 3) | Retail: 50% Coinsurance ; subject to Rx drug deductible | Not covered | Mail orders are subject to 2.5x retail cost-sharing amount. \$1,500 individual / \$3,000 family Rx drug deductible for preferred brand, 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. \$1,500 individual / \$3,000 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | 50% Coinsurance | 50% Coinsurance ; deductible does not apply | Covered No Limit. |
| | Emergency medical transportation | 50% Coinsurance | 50% Coinsurance ; deductible does not apply | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. |
| | Urgent care | \$60 Copay / visit | Not covered | Covered No Limit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 Copay /Office Visit; 50% Coinsurance for other outpatient services | Not covered | Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization). |
| | Inpatient services | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | \$50 Copay / visit | Not covered | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 50% 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 | 50% Coinsurance | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 50% Coinsurance | Not covered | Prior authorization may be required. Limited to 100 visits per year. (Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit, except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.) |
| | Rehabilitation services | \$50 Copay /Office Visit for physical and occupational therapy; 50% Coinsurance for other services | Not covered | Prior authorization may be required. Per year, limited to 25 visits per therapy (occupational, speech and physical therapy); Limited to 25 visits for pulmonary therapy; Limited to 36 visits for cardiac therapy; Limited to 20 visits for cognitive therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. |

| 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) | |
| | Habilitation services | \$50 Copay /Office Visit for physical and occupational therapy; 50% Coinsurance for other services | Not covered | Prior authorization may be required. Per year, limited to 25 visits per therapy (occupational, speech and physical therapy); Limited to 25 visits for pulmonary therapy; Limited to 36 visits for cardiac therapy; Limited to 20 visits for cognitive therapy. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis. |
| | Skilled nursing care | 50% Coinsurance | Not covered | Prior authorization may be required. Limited to 90 days per year. |
| | Durable medical equipment | 50% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | No charge | No charge; deductible does not apply | Prior authorization may be required. Covered No Limit. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Limited to 1 visit per year. |
| | Children's glasses | No charge | Not covered | Limited to 1 item per year. |
| | Children's dental check-up | Not covered | Not covered | -----None----- |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | | |
|--|--|--|--|
| <ul style="list-style-type: none"> Abortion (Except in cases of rape, incest, or when the life of the mother is endangered.) Acupuncture Bariatric surgery Cosmetic surgery Dental care | <ul style="list-style-type: none"> Infertility treatment (Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.) Long-Term Care (Note: Long Term Acute Rehabilitation (LTAC) is a covered benefit. Long Term Nursing Home/Custodial Care is not a covered benefit.) | <ul style="list-style-type: none"> 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 (Limited to 20 visits per year.)
- Private-duty nursing (Limited to 250 visits per year.)
- Routine foot care (Coverage is limited to diabetes care only.)
- Hearing aids (Limited to 1 per ear every 3 years.)

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 WellCare of Kentucky at 1-833-705-2175 (TTY 711); Public Protection Cabinet 500 Mero Street Frankfort, KY 40601, Phone No. 1-502-564-3630. 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: Public Protection Cabinet 500 Mero Street Frankfort, KY 40601, Phone No. 1-502-564-3630.

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 1-833-705-2175 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-705-2175 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-705-2175 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-705-2175 (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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|----------|---|---------|--|---------|
| ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$90 | ■ Specialist copayment | \$90 | ■ Specialist copayment | \$90 |
| ■ Hospital (facility) coinsurance | 50% | ■ Hospital (facility) coinsurance | 50% | ■ Hospital (facility) coinsurance | 50% |
| ■ Other coinsurance | 50% | ■ Other coinsurance | 50% | ■ Other coinsurance | 50% |
| This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles * | \$10 | Deductibles * | \$1,500 | Deductibles * | \$10 |
| Copayments | \$600 | Copayments | \$700 | Copayments | \$500 |
| Coinsurance | \$4,400 | Coinsurance | \$1,400 | Coinsurance | \$1,000 |
| What isn't covered | | What isn't covered | | What isn't covered | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,070 | The total Joe would pay is | \$3,620 | The total Mia would pay is | \$1,510 |

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

| | |
|----------------------------|---|
| Spanish: | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from WellCare of Kentucky, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-705-2175 (TTY 711). |
| Chinese: | 如果您，或是您正在協助的對象，有關於 Ambetter from WellCare of Kentucky，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 1-833-705-2175 (TTY 711)。 |
| German: | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from WellCare of Kentucky 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 1-833-705-2175 (TTY 711) an. |
| Vietnamese: | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from WellCare of Kentucky, 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 1-833-705-2175 (TTY 711). |
| Arabic: | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from WellCare of Kentucky ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-705-2175 (TTY 711). |
| Serbo-Croatian: | Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from WellCare of Kentucky, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-833-705-2175 (TTY 711). |
| Japanese: | Ambetter from WellCare of Kentucky 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、1-833-705-2175 (TTY 711) までお電話ください。 |
| French: | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from WellCare of Kentucky, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le 1-833-705-2175 (TTY 711). |
| Korean: | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from WellCare of Kentucky 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-705-2175 (TTY 711)번으로 전화하십시오. |
| Pennsylvania Dutch: | Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from WellCare of Kentucky, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza miitt ebbah diveyya, kaw! 1-833-705-2175 (TTY 711). |
| Nepali: | यदि तपाईं स्वयं वा तपाईंले मद्दत गर्दै गरेको व्यक्तिसँग Ambetter from WellCare of Kentucky को बारेमा प्रश्नहरू छन् भने तपाईंसँग तपाईंलाई कुनै खर्च नलाग्ने गरी आफ्नो भाषामा मद्दत तथा जानकारी प्राप्त गर्ने अधिकार हुन्छ । दोभाषेसँग कुरा गर्नको लागि 1-833-705-2175 (TTY 711) मा फोन गर्नुहोस् । |
| Cushite: | Isin yookan namni biraa isin deeggartan Ambetter from WellCare of Kentucky irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-833-705-2175 (TTY 711) tiin bilbilaa. |
| Russian: | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from WellCare of Kentucky вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-705-2175 (TTY 711). |
| Tagalog: | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from WellCare of Kentucky, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-705-2175 (TTY 711). |
| Bantu: | Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from WellCare of Kentucky, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-833-705-2175 (TTY 711). |

Statement of Non-Discrimination

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

Ambetter from WellCare of Kentucky:

- 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 WellCare of Kentucky at 1-833-705-2175 (TTY 711).

If you believe that Ambetter from WellCare of Kentucky 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 WellCare of Kentucky, Attn: Appeals & Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-705-2175 (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 from WellCare of Kentucky 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>.