Coverage Period: 01/01/2023 – 12/31/2023

Coverage for: Individual/Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <a href="https://ambetter.sunflowerhealthplan.com/2023-brochures.html">https://ambetter.sunflowerhealthplan.com/2023-brochures.html</a>, 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 <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> 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?	\$5,450 individual / \$10,900 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 deductible?	Yes, <u>Preventive care</u> services, primary care, <u>specialist</u> , <u>urgent care</u> office visits and generic and preferred brand drugs are covered before you meet your <u>deductible</u> except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$8,400 individual / \$16,800 family. Not applicable for <u>out-of-network providers</u> .	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain preauthorization for services 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 <a href="https://ambetter.sunflowerhealthplan.com/findadoc">https://ambetter.sunflowerhealthplan.com/findadoc</a> or call 1-844-518-9505 (TTY/TDD 1-844-546-9713) for a list of <a href="network providers">network providers</a> .	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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Camman		What You	u Will Pay	Limitations Executions 9 Other Important
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 Copay / ; deductible does not apply	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.
If you visit a health care provider's office or clinic	Specialist visit	\$50 Copay /; deductible does not apply	Not covered	Covered No Limit.
or clinic	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$25 Copay /; deductible does not apply for laboratory & professional services  30% Coinsurance for x-ray & diagnostic imaging  30% 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)	30% 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 /; deductible does not apply  Generic Retail: \$25 Copay /; 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.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
More information about prescription drug	Preferred brand drugs (Tier 2)	Retail: \$50 Copay /; deductible does not apply	Not covered	Prior authorization may be required.  Prescription drugs are provided up to 30 days	
coverage is available at https://ambetter.sunflo werhealthplan.com/20	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	retail and up to 90 days through mail order.  Mail orders are subject to 2.5x retail cost- sharing amount.	
23formulary.	Specialty drugs (Tier 4)	Retail: 50% 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	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
surgery	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
	Emergency room care	30% Coinsurance	30% Coinsurance	Covered No Limit.	
If you need immediate medical attention	Emergency medical transportation	30% Coinsurance	30% <u>Coinsurance</u>	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of <a href="mailto:network">network</a> ground/water ambulance <a href="mailto:provider">provider</a> , you may be subject to <a href="mailto:balance">balance</a> <a href="mailto:billing">billing</a> .	
	<u>Urgent care</u>	\$60 <u>Copay</u> / ; <u>deductible</u> does not apply  Not covered	Not covered	Covered No Limit.	
If you have a hospital	Facility fee (e.g., hospital room)	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
stay	Physician/surgeon fees	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
If you need mental health, behavioral health, or substance	Outpatient services	\$25 <u>Copay</u> / office visit; <u>deductible</u> does not apply; 30% <u>Coinsurance</u>	Not covered	Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization).	
abuse services	Inpatient services	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you are pregnant	Office visits	\$25 Copay / ; 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	30% Coinsurance	Not covered	Prior authorization may be required. Cost- sharing does not apply for preventive	
	Childbirth/delivery facility services	30% Coinsurance	Not covered	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).	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not covered	Prior authorization may be required. Note: Includes educational visits - limited to 3 per year.	
	Rehabilitation services	Outpatient: 30% Coinsurance Inpatient: 30% Coinsurance	Not covered	Outpatient: 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. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.	
	Habilitation services	Outpatient: 30% Coinsurance Inpatient:	Not covered	Outpatient: Prior authorization may be required. Covered No Limit.	

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
		30% Coinsurance		Inpatient: Prior authorization may be required. Covered No Limit.
	Durable medical equipment	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	30% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Respite Care is covered as part of hospice services only.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Eye exams are covered as appropriate.  Additional visits beyond the initial exam will be billed as specialist visits.
	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 (Except in cases of rape, incest, or when the life of the mother is endangered.)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)

- Infertility treatment (Limited to diagnosis and treatment of cause of infertility.)
- Hearing aids
  - 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)
- Skilled nursing care
- Weight loss programs

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

Private-duty nursing

Routine foot care

Spinal manipulation

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 <a href="Plan">Plan</a> at 1-844-518-9505 (TTY/TDD 1-844-546-9713); Kansas Insurance Department, 1300 SW Arrowhead Rd Topeka, KS 66604, Phone No. 1-785-296-3071.; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Kansas Health Options at 1-800-432-2484; Office of Personnel Management Multi State Plan Program at <a href="https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/">https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="https://www.healthcare.gov">health Insurance Marketplace</a>. For more information about the <a href="https://www.healthcare.gov">Marketplace</a>, visit <a href="https://www.healthcare.gov">www.healthcare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Kansas Insurance Department, 1300 SW Arrowhead Rd Topeka, KS 66604, 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? 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 1-844-518-9505 (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:**



■ Other coinsurance

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%

### 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
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# In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covere	ed
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 <u>plan's</u> overall <u>deductible</u>	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

<u>Diagnostic tests</u> (blood work)
Prescription drugs

30%

Total Example Cost	\$5,600

# In this example, Joe would pay:

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Cost Sharin	g
<u>Deductibles</u>	\$0
Copayments	\$0
Coinsurance	\$0
What isn't cove	ered
Limits or exclusions	\$0
The total Joe would pay is	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic tests (x-ray)

<u>Durable medical equipment</u> (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

## In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$0	



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 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 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 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 1-844-546-9713) 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 1-844-546-9713) 로 전화하십시오.
Laotian:	ຖ້ າທ່ານ ຫຼື ຄົ ນ <sup>່</sup> ທທ່ານກຳລັງຊ່ວຍເຫຼື ອ ມໍຄາຖາມກ່ຽວກັບ Ambetter from Sunflower Health Plan, ທ່ານ ມິສດ <sup>່</sup> ທຈະໄດ້ ຮັບການຊ່ວຍເຫຼື ອແລະໍຂ້ ມູນຂ່າວສານ <sup>່</sup> ທເປັ ນພາສາຂອງທ່ານ ໂດຍໍ່ບມ ຄ່າໃຊ້ ຈ່າຍ. ເພີ່ຼື ອຈະເ∂້ອ າກັ ບນາຍພາສາ ໃຫ້ ໂທຫາ 1-844-518-9505
Arabic:	لديك الحق نبي الحصول على الهبراعدة والمعلومات الخبرورية للبتك من دون أية ثلانة. للنحدث مع ، Plan Health Sunflower from Ambetter إذا لهان لديك أو لدى شخص نسراعده أسنلة حول مهرج مانصل بـ (9713-484-177) 9505-1844-18.
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 1-844-546-9713).
Burmese:	သင္ သို္မဟာုတ္ သင္းႏက <b>ူညီေနသ</b> ူတစ္ဦးႏွီးတင္ Ambetter from Sunflower Health Plan အေဳက <b>ာင္း ေမးစရ</b> ာမ <b>ီ</b> ားရပိမ္မက အခမဲဲ့အက <b>ူအည</b> ီ ရယ <b>ူပိုင္ခန္းႏွာ္ သင</b> ္၏ဘာသ <b>ာ စကားဴဖင</b> ့္ အခ်ဳိက္ အလက္ မစဳားကိ္ အခမဲဲ့ရယ <b>ူပ</b> ိုင္ခင့္ ရပိပၝသည္။ စကားဴပန <b>္</b> တစ္္ဦီးႏႈင့္ စကားေဴပ <b>ာဆ</b> ိုရန္္ 1-844-518-9505 (TTY 1-844-546-9713) ကို ဖုန္းဆက္ပၝ။
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 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 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 (ТТҮ 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:	داريد، از اپن حق برخوردارېد که کمک و اطالعات را بصورت Plan Health Sunflower from Ambetter اگر شهما، ېا کسې که به او کمک مي کنډ سوالي در مورد نماس بگڼړېد9505-518-1844 TTY) (رايگان به زبان خود درېانت کنږ. بر اي صحبت کردن با مېرجم با شماره 1-844-546-9713
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 1-844-546-9713).

#### 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 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 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.