Ambetter of Oklahoma
Elite Bronze + Vision + Adult Dental: Limited Cost Sharing Plan Variation

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/2023-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 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. Preventive care services, urgent care office visits, children's eye exam and glasses, generic and preferred brand drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or Yes, $3,800 individual / $7,600 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: $8,700 individual / $17,400 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://ambetterofoklahoma.com/findadoc or call 1-833-492-0679 (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
		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	$45 Copay / visit	30% Coinsurance	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full. Cost sharing waived at non-IHCP with IHCP referral.
	Specialist visit	No charge	$115 Copay / visit	30% Coinsurance	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	No charge	30% 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)	No charge	$60 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	30% Coinsurance	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	50% Coinsurance	30% Coinsurance	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://ambetterofoklahoma.com/2023formulary**.	Generic drugs (Tier 1)	No charge	Preferred Generic Retail: $5 Copay / prescription Generic Retail: $35 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 3x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral.
	Preferred brand drugs (Tier 2)	No charge	Retail: $195 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 3x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral.
	Non-preferred brand drugs (Tier 3)	No charge	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 3x retail cost-sharing amount. $3,800 individual / $7,600 family Rx drug deductible for non-preferred brand and specialty drugs. Cost sharing waived at non-IHCP with IHCP referral.
	Specialty drugs (Tier 4)	No charge	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. Cost sharing waived at non-IHCP with IHCP referral.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% Coinsurance	30% Coinsurance	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	50% Coinsurance	30% Coinsurance	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	$2,500 Copay / visit ($1250 Copay / visit for facility; $1250 Copay /	$2,500 Copay / visit ($1250 Copay / visit; deductible does not apply for facility;	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.

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		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)	
			visit for physician fee)	$1250 Copay / visit; deductible does not apply for physician fee)	
	Emergency medical transportation	No charge	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. If you receive service from an out of network ground/water ambulance provider, you may be subject to balance billing. Cost sharing waived at non-IHCP with IHCP referral.
	Urgent care	No charge	$60 Copay / visit	30% Coinsurance; deductible does not apply	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	$3000 Copay / day	30% Coinsurance	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	No charge	30% Coinsurance	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	$45 Copay / office visit; 50% Coinsurance	30% Coinsurance	Prior authorization may be required. Covered No Limit. (Primary care provider (PCP) and other practitioner visits do not require prior authorization).Cost sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	$3000 Copay / day	30% Coinsurance	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	$45 Copay / visit	30% 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

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)	
					the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery professional services	No charge	No charge	30% 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). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery facility services	No charge	$3000 Copay / day	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% Coinsurance	30% Coinsurance	Prior authorization may be required. Limited to 30 visits per year. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	Outpatient: 50% Coinsurance Inpatient: $3000 Copay / day	Outpatient: 30% Coinsurance Inpatient: 30% Coinsurance	Outpatient: 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. Inpatient: Prior authorization may be required. Limited to 30 days per year. 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	Outpatient:50% Coinsurance Inpatient: $3000 Copay / day	Outpatient: 30% Coinsurance Inpatient: 30% Coinsurance	Outpatient: 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. Inpatient: Prior authorization may be required. Limited to 30 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. 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)	
	Skilled nursing care	No charge	$3000 Copay / day	30% Coinsurance	Prior authorization may be required. Limited to 30 days per year. Cost sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No charge	50% Coinsurance	30% Coinsurance	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	50% Coinsurance	30% Coinsurance	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	No charge	Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No charge	No charge	No charge	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 when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental (Children)
- 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.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Limited to 1 surgery per lifetime.) • Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care).)	• Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.) • Infertility treatment (Coverage is provided for diagnostic, counseling, and planning services for treatment of an underlying cause of infertility.)	• Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.) • Routine foot care • Weight loss programs

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; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Health Options at 1-800-522-0071; Office of Personnel Management Multi State Plan Program at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. 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, kwiijigo 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	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

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	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

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	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

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 of Oklahoma, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-492-0679 (TTY 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Oklahoma , 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 1-833-492-0679 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of Oklahoma 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 1-833-492-0679 (TTY 711)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Oklahoma 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-492-0679 (TTY 711)번으로 전화하십시오.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Oklahoma 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 1-833-492-0679 (TTY 711) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter of Oklahoma، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-492-0679 (TTY 711).
Burmese:	သင် သို့မဟုတ် သင်ကူညီပေးနေသော တစ်ယောက်ယောက်တွင် Ambetter of Oklahoma နှင့် ပက်သက်ပြီး မေးမြန်းလိုသည်များ ရှိလျှင် အကူအညီ နှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရယူပိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန်တစ်ယောက် နှင့် ပြောဆိုရန် 1-833-492-0679 (TTY 711) ကို ဖုန်းဆက်ပါ။
Hmong:	Yog koj, los yog ib tug neeg uas koj pab ntawd, muaj lus nug txog Ambetter of Oklahoma koj muaj cai tau txais tej ntub ntawv no sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-833-492-0679 (TTY 711)
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of Oklahoma, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-492-0679 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d’Ambetter of Oklahoma, vous avez le droit de bénéficier gratuitement d’aide et d’informations dans votre langue. Pour parler à un interprète, appelez le 1-833-492-0679 (TTY 711).
Laotion:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter of Oklahoma, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-492-0679 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับAmbetter of Oklahoma ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-492-0679 (TTY 711).
Urdu:	اگر Ambetter of Oklahoma کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے 1-833-492-0679 (TTY 711) پر کال کریں۔
Cherokee:	ᏂᎯ ᎠᏍ ᎯᏍᏕᎵᏍᎩ ᏫᏯ ᎠᎹᎹᏜᏍᎩ ᎬᏩᏕᎾᎹ Ambetter of Oklahoma, ᏙᏩ ᎠᏯ ᎡᏍᏕᏗᎢ ᎠᏍ ᎡᏣᏃᏍᏎᏗ ᏣᏍᏌ ᏣᏬᏂᎯᏍᏗ ᏂᏚ ᎬᏩᎹᎾ. ᏍᏓᏲᏃᏢᏗ ᏱᏣ ᎠᏁᏗᏍᎩ ᏗᏫᎾ 1-833-492-0679 (TTY 711)
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter of Oklahoma داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-833-492-0679 (TTY 711) تماس بگيريد.

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*.