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

https://ambetterofoklahoma.com/2023-brochures.html, or call 1-833-492-0679 (TTY 711). For general definitions of common terms, such as <u>allowed amount</u>, <u>balance</u> <u>billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> 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> : \$5,000 Individual / \$10,000 Family. <u>Out-of-network providers</u> : \$9,900 Individual / \$19,800 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</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$7,250 Individual / \$14,500 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-</u> <u>of-pocket limit</u> ?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>https://ambetterofoklahoma.com/findadoc</u> or call 1-833-492-0679 (TTY 711) for a list of <u>network</u> <u>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</u> <u>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

SBC-62505OK0130007-04-2023

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		services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and	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 Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information		
lf vou visit e besléh	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% <u>Coinsurance</u>	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, <u>providers</u> covered in full, <u>deductible</u> does not apply.		
If you visit a health care <u>provider's</u> office	<u>Specialist</u> visit	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% Coinsurance	Covered No Limit.		
	Preventive care/screening/ immunization	No charge; <u>deductible</u> does not apply	60% <u>Coinsurance;</u> <u>deductible</u> does not apply	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	<u>Diagnostic test</u> (x-ray, blood work)	<ul> <li>\$25 <u>Copay</u> / test; <u>deductible</u> does not apply for laboratory &amp; professional services</li> <li>40% <u>Coinsurance</u> for x- ray &amp; diagnostic imaging</li> <li>40% <u>Coinsurance</u> for laboratory &amp; professional services and x-ray &amp;</li> </ul>	<ul> <li>60% <u>Coinsurance</u> for laboratory &amp; professional services</li> <li>60% <u>Coinsurance</u> for x- ray &amp; diagnostic imaging</li> <li>60% <u>Coinsurance</u> for laboratory &amp; professional services and x-ray &amp; diagnostic imaging at</li> </ul>	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)	diagnostic imaging at other places of service 40% <u>Coinsurance</u>	other places of service	Prior authorization may be required. Covered No Limit.		

Common		What You	u Will Pay	Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Information
		(You will pay the least)	(You will pay the most)	
If you need drugs to treat your illness or condition More information about	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 <u>Copay</u> / prescription; <u>deductible</u> does not apply Generic Retail: \$20 <u>Copay</u> / prescription; <u>deductible</u> does not apply	Not covered	Prior authorization may be required. <u>Prescription</u> <u>drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.
prescription drug coverage is available at https://ambetterofokla	Preferred brand drugs (Tier 2)	Retail: \$50 <u>Copay</u> / prescription; <u>deductible</u> does not apply	Not covered	Prior authorization may be required. <u>Prescription</u> <u>drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are
homa.com/2023formul ary.	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	subject to 3x retail <u>cost-sharing</u> amount.
	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)	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
surgery	ery         Physician/surgeon fees         40% Coinsurance         60% Coinsurance		60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Emergency room care	40% Coinsurance	40% Coinsurance	Covered No Limit.
If you need immediate medical attention	Emergency medical transportation	40% <u>Coinsurance</u>	40% <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 <u>network</u> ground/water ambulance <u>provider</u> , you may be subject to <u>balance billing</u> .
	<u>Urgent care</u>	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% <u>Coinsurance;</u> <u>deductible</u> does not apply	Covered No Limit.
If you have a hospital	Facility fee (e.g., hospital room)	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.

Common		What You	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 need mental health, behavioral health, or substance	Outpatient services	\$20 <u>Copay</u> / office visit; <u>deductible</u> does not apply; 40% <u>Coinsurance</u>	60% Coinsurance	Prior authorization may be required. Covered No Limit. ( <u>Primary care provider</u> (PCP) and other practitioner visits do not require prior authorization).
abuse services	Inpatient services	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
lf you are pregnant	Office visits	\$20 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% <u>Coinsurance</u>	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <u>Cost-sharing</u> does not apply for <u>preventive</u> <u>services</u> , such as routine pre-natal and post-natal <u>screenings</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% Coinsurance	60% Coinsurance	Prior authorization may be required. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending
	Childbirth/delivery facility services	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Home health care	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 30 visits per year.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: 40% <u>Coinsurance</u> Inpatient: 40% <u>Coinsurance</u>	Outpatient: 60% <u>Coinsurance</u> Inpatient: 60% <u>Coinsurance</u>	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.

Common	Common Medical Event Services You May Need		u Will Pay	Limitations, Exceptions, & Other Important
			Out-of-Network Provider (You will pay the most)	Information
	Habilitation services	Outpatient: 40% <u>Coinsurance</u> Inpatient: 40% <u>Coinsurance</u>	Outpatient: 60% <u>Coinsurance</u> Inpatient: 60% <u>Coinsurance</u>	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.
	Skilled nursing care	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 30 days per year.
	Durable medical equipment	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	40% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Children's eye exam	No charge; <u>deductible</u> does not apply	Covered up to \$38.50; deductible does not apply	Limited to 1 visit per year. <u>Out-of-network provider</u> eye exam covered up to \$38.50.
If your child needs dental or eye care	Children's glasses	No charge; <u>deductible</u> does not apply	Covered up to \$50; <u>deductible</u> does not apply	Limited to 1 item per year. <u>Out-of-network</u> 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 when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery

- Cosmetic surgery
- Dental care (Children)
- 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.
- 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.)			
• Dental care (Adult-visit & item limits apply per	• Private-duty nursing (Limited to 85 visits per	year. Dollar allowance applies to hardware.)		

- year. \$1,000 annual dollar limit per year per person.)
- year.)
- Routine foot care

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.



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.

<b>Peg is Having a Baby</b> (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	\$5,000	The plan's overall deductible	\$5,000	The plan's overall deductib	ole \$5,000
Specialist copayment	\$50	Specialist copayment	\$50	Specialist copayment	\$50
Hospital (facility) coinsurance	40%	Hospital (facility) <u>coinsurance</u>	40%	Hospital (facility) coinsurar	<u>nce</u> 40%
Other <u>coinsurance</u>	40%	Other <u>coinsurance</u>	40%	Other <u>coinsurance</u>	40%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)		This EXAMPLE event includes service <u>Primary care physician</u> office visits (includes as education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose medical equipment)	luding	This EXAMPLE event includes Emergency room care (including Diagnostic tests (x-ray) Durable medical equipment (cru Rehabilitation services (physical	g medical supplies) ıtches)
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800

# In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$2,200
What isn't covere	ed
Limits or exclusions	\$60
The total Peg would pay is	\$5,960

Specialist copayment	
Hospital (facility) coinsurar	ice 4
Other <u>coinsurance</u>	4
This EXAMPLE event includes	s services like:
Primary care physician office vis	sits (including
disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glu	cose meter)
Total Example Cost	\$5,

# In this example, Joe would pay:

Cost Sharing			
Deductibles	\$800		
<u>Copayments</u>	\$1,200		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$2,020		

# In this example, Mia would pay:

Cost Sharing			
Deductibles	\$2,500		
<u>Copayments</u>	\$200		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$2,700		



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 1-333-492-0679 (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, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-492-0679 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับAmbetter of Oklahoma ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ดิดต่อที่หมายเลข1-833-492-0679 (TTY 711).
Urdu:	اگر Ambetter of Oklahoma کے بار ے 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 1-833-492-0670 (TTY 711) پر کال کریں۔
Cherokee:	ႹჅ Dኖ ჅႫႽႼႫႸ ႫႵ Dኖኖ&ႫႸ EGSOኖ Ambetter of Oklahoma, VG Dቶ RႫႽჃT Dኖ RGZႫ4Ⴣ C-ႫႸ ႺಲႹჅႫჃ ႹႽ EG.ኖѲ. ႫႱ&ჍႼჃ ႸႺ DハჃႫႸ ჃჇѲ 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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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.