




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/2024-brochures.html>, or call 1-833-492-0679 (TTY 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-833-492-0679 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or <u>network providers</u> : \$900 Individual / \$1,800 Family. <u>Out-of-network providers</u> : \$2,700 Individual / \$5,400 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, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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 limit</u> for this <u>plan</u> ? | For <u>network providers</u> : \$8,700 Individual / \$17,400 Family. For <u>out-of-network providers</u> : Not applicable Individual / Not applicable Family. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> 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 https://ambetterofoklahoma.com/findadoc or call 1-833-492-0679 (TTY 711) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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 | \$25 Copay / visit; deductible does not apply | 50% Coinsurance | Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full, deductible does not apply. Cost sharing waived at non-IHCP with IHCP referral . |
| | Specialist visit | No charge | \$60 Copay / visit; deductible does not apply | 50% Coinsurance | None. Cost sharing waived at non-IHCP with IHCP referral . |
| | Preventive care/screening/immunization | No charge | No charge; deductible does not apply | 50% 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. Cost sharing waived at non-IHCP with IHCP referral . |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 30% Coinsurance for laboratory & professional services 30% Coinsurance for x-ray & diagnostic imaging 30% Coinsurance for laboratory & professional services and x-ray & diagnostic | 50% Coinsurance for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray | 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. 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) | |
| | | | imaging at other places of service | & diagnostic imaging at other places of service | |
| | Imaging (CT/PET scans, MRIs) | No charge | 30% Coinsurance | 50% Coinsurance | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambetterofoklahoma.com/2024formulary . | Generic drugs (Tier 1) | No charge | Preferred Generic Retail: \$3 Copay / prescription; deductible does not apply Generic Retail: \$15 Copay / prescription; deductible does not apply | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral . |
| | Preferred brand drugs (Tier 2) | No charge | Retail: \$40 Copay / prescription; deductible does not apply | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral . |
| | Non-preferred brand drugs (Tier 3) | No charge | Retail: 50% Coinsurance | Not covered | Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Cost sharing waived at non-IHCP with IHCP referral . |
| | Specialty drugs (Tier 4) | No charge | 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. Cost sharing waived at non-IHCP with IHCP referral . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 30% Coinsurance | 50% Coinsurance | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Physician/surgeon fees | No charge | 30% Coinsurance | 50% 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 immediate medical attention | Emergency room care | No charge | 30% Coinsurance | 30% Coinsurance | None. Cost sharing waived at non-IHCP with IHCP referral . |
| | Emergency medical transportation | No charge | 30% Coinsurance | 30% Coinsurance | 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; deductible does not apply | 50% Coinsurance ; deductible does not apply | None. Cost sharing waived at non-IHCP with IHCP referral . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 30% Coinsurance | 50% Coinsurance | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Physician/surgeon fees | No charge | 30% Coinsurance | 50% 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 | Office Visit: \$25 Copay / visit; deductible does not apply; Other Outpatient Services: 30% Coinsurance | 50% Coinsurance | Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) Cost sharing waived at non-IHCP with IHCP referral . |
| | Inpatient services | No charge | 30% Coinsurance | 50% 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 | \$25 Copay / visit; deductible does not apply | 50% 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 |

| 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) | |
| | | | | | 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 professional services | No charge | 30% Coinsurance | 50% 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 | 30% Coinsurance | 50% Coinsurance | |
| If you need help recovering or have other special health needs | Home health care | No charge | 30% Coinsurance | 50% 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: \$35 Copay / visit; deductible does not apply Inpatient: 30% Coinsurance | Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance | Outpatient: Prior authorization may be required. Limited to a combined 25 visit limit 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: \$35 Copay / visit; deductible does not apply Inpatient: 30% Coinsurance | Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance | Outpatient: Prior authorization may be required. Limited to a combined 25 visit limit 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 |

| 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) | |
| | | | | | provided for a mental health/substance use disorder diagnosis. Cost sharing waived at non-IHCP with IHCP referral . |
| | Skilled nursing care | No charge | 30% Coinsurance | 50% 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 | 30% Coinsurance | 50% Coinsurance | Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral . |
| | Hospice services | No charge | 30% Coinsurance | 50% 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; deductible does not apply | Covered up to \$38.50; deductible does not apply | Limited to 1 visit per year. Out-of-network provider eye exam covered up to \$38.50. |
| | Children's glasses | No charge | No charge; deductible does not apply | Covered up to \$50; deductible does not apply | Limited to 1 item per year. Out-of-network provider frames or contacts covered up to \$50, see schedule for lens limit. |
| | Children's dental check-up | Not covered | Not covered | 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 when the life of the mother is endangered) • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Children) • Infertility treatment | <ul style="list-style-type: none"> • Long-term care • 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
- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)
- Hearing aids (Limited to 1 per ear every 4 years.)
- Private-duty nursing (Limited to 85 visits per year.)
- Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.)
- 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, kwijigo 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 | \$900 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | |
| Total Example Cost | \$12,700 |

In this example, Peg would pay:

| 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 | \$900 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | |
| Total Example Cost | \$5,600 |

In this example, Joe would pay:

| 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 | \$900 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$2,800 |

In this example, Mia would pay:

| 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.

English: If you, or someone you are helping, have questions about Ambetter of Oklahoma, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-492-0679 (TTY 711).

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Oklahoma y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-833-492-0679 (TTY 711).

Vietnamese: Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter of Oklahoma và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 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，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-833-492-0679 (TTY 711)。

Korean: 귀하 또는 귀하의 도움을 받는 분이 Ambetter of Oklahoma에 대한 질문이 있는 경우 영어에 능숙하지 않으면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-833-492-0679(TTY 711)번으로 가입자 서비스부에 연락하십시오.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Oklahoma hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-833-492-0679 (TTY 711).

Arabic: إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Oklahoma، ولم تكن بارعا بالغة الإنكليزية، ف لديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعد تعاني من حالة سمعية و/أو بصرية تعيق التواصل، ف لديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال ب خدمات الأعضاء على 1-833-492-0679 (TTY 711).

Burmese: အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် Ambetter of Oklahoma အကြောင်းနှင့် ပတ်သက်၍ မေးခွန်းများ မေးလိုပြီး အင်္ဂလိပ်လို ကျွမ်းကျင်စွာ မပြောနိုင်ပါက၊ သင့်တွင် အကူအညီနှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ အကယ်၍ သင် သို့မဟုတ် သင်ကူညီနေသူတစ်ဦးသည် ဆက်သွယ်ရေးကို အဟန့်အတားဖြစ်စေသော အကြားအာရုံ နှင့်/သို့မဟုတ် အမြင်အာရုံနှင့် သက်ဆိုင်သော အခြေအနေတစ်ခုရှိပါက၊ သင့်တွင် အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကို အခကြေးငွေ ပေးစရာမလိုဘဲ အချိန်နှင့်တစ်ပြေးညီ ရယူပိုင်ခွင့်ရှိသည်။ ဘာသာပြန် သို့မဟုတ် အရန်ဝန်ဆောင်မှုများကို လက်ခံရယူရန် 1-833-492-0679 (TTY 711) ရှိ အဖွဲ့ဝင် ဝန်ဆောင်မှုများ ကို ဆက်သွယ်ပါ။

Hmong: Yog tias koj, los sis ib tug neeg twg uas koj tab tom muab kev pab, muaj cov lus nug hais txog Ambetter of Oklahoma, thiab tsis paub lus Askiv zoo heev, koj muaj cai tau txais kev pab thiab tej ntaub ntauw qhia paub ua koj hom lus yam tsis tau them dab tsi li thiab kom tau raws sij hawm. Yog tias koj, los sis ib tug neeg twg uas koj tab tom pab, muaj tsos mob txog kev hnov lus thiab/los sis kev pom kev uas cuam tshuam txog kev sib txuas lus, koj muaj cai kom tau txais cov kev pab thiab cov kev pab cuam ntxiv yam tsis tau them dab tsi li thiab kom tau raws sij hawm. Txhawm rau kom tau txais cov kev pab cuam txhais ntauw los sis kev pab ntxiv, thov tiv tauj Member Services (Cov Chaw Muab Kev Pab Cuam Tswv Cuab) tau ntawm 1-833-492-0679 (TTY 711).

Tagalog: Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter of Oklahoma, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-492-0679 (TTY 711).

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| French: | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Oklahoma et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-833-492-0679 (TTY 711). |
| Laotian: | ຖ້າທ່ານຫາກ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກ່າວວ່າໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter of Oklahoma, ແລະ ບໍ່ຊ່ວຍຊາບພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທຳນຽມ. ຖ້າທ່ານຫາກ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກ່າວວ່າໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທຳນຽມ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໄດ້ທີ່ 1-833-492-0679 (TTY 711). |
| Thai: | หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter of Oklahoma และไม่สามารถใช้ในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายผ่านทางที่ หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายผ่านทางที่ หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-833-492-0679 (TTY 711) |
| Urdu: | اگر آپ، یا جس کی آپ مدد کر رہے ہیں وہ Ambetter of Oklahoma کے بارے میں سوالات کرنا چاہتے ہیں، اور وہ انگریزی میں ماہر نہیں ہیں، تو آپ کو اپنی زبان میں بلا معاوضہ اور بروقت مدد اور معلومات حاصل کرنے کا حق ہے۔ اگر آپ، یا جس کی آپ مدد کر رہے ہیں، انہیں سماعت اور/یا بصارت میں کوئی پریشانی درپیش ہو جس سے مواصلت میں رکاوٹ پیدا ہوتی ہے، تو آپ کو مفت اور ہر وقت معاون امداد اور خدمات حاصل کرنے کا حق ہے۔ ترجمہ یا معاون خدمات حاصل کرنے کے لیے، براہ کرم سے 1-833-492-0679 (TTY 711) پر ممبر سروسز سے رابطہ کریں۔ |
| Cherokee: | Ej h̄t̄ T̄āw̄, D̄ YGT ʌD ʃ̄w̄w̄ D̄w̄s̄, ʌVLID ʌSLW ʌr̄JC̄ DL̄w̄_SAD, D̄ ʃ̄GW̄w̄ ʃ̄w̄J̄ Db̄θ̄ Ambetter of Oklahoma, T̄āw̄ ʌVLID Z̄d̄ DJ̄w̄ ʃ̄r̄w̄ DYD D̄w̄s̄ D̄ ʃ̄l̄w̄ EJ T̄āw̄ TELT̄w̄ ʃ̄h̄c̄ ʃ̄J̄ d̄EḠḠJ̄ D̄ EJ a T̄Ḡh̄h̄ DĒʃ̄JC̄. EJ h̄t̄ T̄āw̄, D̄ YGT ʌD ʃ̄w̄w̄ D̄w̄s̄, ʌVLID Z̄d̄ D̄ʃ̄w̄ D̄ʃ̄/ D̄ʃ̄ ʃ̄h̄Ḡw̄l̄w̄ ʃ̄ḠY ʃ̄w̄ DW̄ʃ̄w̄ ʌJ̄d̄ET, T̄āw̄ ʌVLID Z̄d̄ DJ̄w̄ ʃ̄r̄w̄ ʃ̄ll̄h̄ʃ̄ D̄4ʃ̄ D̄w̄s̄ D̄ ʌVW̄h̄ ʃ̄h̄c̄ ʃ̄J̄ d̄EḠḠJ̄ D̄ EJ a T̄Ḡh̄h̄ DĒʃ̄JC̄. ʃ̄r̄w̄ ʃ̄ll̄h̄ʃ̄ D̄l̄w̄ D̄ʃ̄ D̄4ʃ̄ ʌVW̄h̄, DW̄ʃ̄w̄ DR̄h̄ ʃ̄B̄ ʌVW̄h̄ ʃ̄h̄c̄ 1-833-492-0679 (TTY 711). |
| Persian: | اگر شما یا فردی که دارید به او کمک می‌کنید، سوالی درباره Ambetter of Oklahoma دارید، و انگلیسی نمی‌دانید، حق دارید کمک و اطلاعات را به زبان خودتان به رایگان و به موقع دریافت کنید. اگر شما یا فردی که دارید به او کمک می‌کنید مشکلات شنوایی یا بینایی دارد که برقراری ارتباط را سخت می‌کند، حق دارید کمک‌ها و خدمات امدادی را به زبان خودتان به رایگان و به موقع دریافت کنید. برای دریافت کمک‌ها و خدمات امدادی لطفاً با خدمات اعضا به شماره 1-833-492-0679 (TTY 711) تماس بگیرید. |

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Statement of Non-Discrimination

Ambetter of Oklahoma is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Oklahoma Health Insurance Marketplace. Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. © 2023 Celtic Insurance Company. All rights reserved.

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If you, or someone you are helping, have questions about Ambetter of Oklahoma, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-492-0679 (TTY 711). If you believe that Celtic Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-492-0679 (TTY 711). You may also submit a grievance by phone to 1-833-492-0679 (TTY 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>.

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