




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/2025-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?	<u>Network providers</u> : \$7,500 Individual / \$15,000 Family. <u>Out-of-network providers</u> : \$22,500 Individual / \$45,000 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> , and <u>urgent care</u> visits, and certain <u>prescription drugs</u> are covered before you meet your <u>deductible</u> (see additional information below).	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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> : \$9,200 Individual / \$18,400 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 out-of-pocket limit?	<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 network provider?	Yes. See <a href="https://ambetterofoklahoma.com/findadoc">https://ambetterofoklahoma.com/findadoc</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	60% <a href="#">Coinsurance</a>	Covered No Limit.
	<a href="#">Specialist</a> visit	\$100 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	60% <a href="#">Coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	60% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">Coinsurance</a> for laboratory & professional services	60% <a href="#">Coinsurance</a> for laboratory & professional services	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.
		50% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging	60% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging	
	Imaging (CT/PET scans, MRIs)	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs	Tier 1a - Preferred Generic Retail: \$25	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about <a href="https://ambetterofokla.homa.com/2025formulary">prescription drug coverage</a> is available at <a href="https://ambetterofokla.homa.com/2025formulary">https://ambetterofokla.homa.com/2025formulary</a> .		<a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply  Tier 1b - Generic Retail: \$25 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply		orders are subject to 3x retail <a href="#">cost-sharing</a> amount.
	Preferred brand drugs	Tier 2 - Retail: \$50 <a href="#">Copay</a> / prescription	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <a href="#">cost-sharing</a> amount.
	Non-preferred brand drugs and Non-preferred generic drugs	Tier 3 - Retail: \$100 <a href="#">Copay</a> / prescription	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 30 days through mail order.
	<a href="#">Specialty drugs</a>	Tier 4 - Retail: \$500 <a href="#">Copay</a> / prescription	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 30 days through mail order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	50% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	50% <a href="#">Coinsurance</a>	50% <a href="#">Coinsurance</a>	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="#">network</a> water ambulance <a href="#">provider</a> , you may be subject to <a href="#">balance billing</a> .
	<a href="#">Urgent care</a>	\$75 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	60% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply; Other Outpatient Services: 50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	60% <a href="#">Coinsurance</a>	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Limited to 30 visits per year.
	<a href="#">Rehabilitation services</a>	Outpatient: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply Inpatient: 50% <a href="#">Coinsurance</a>	Outpatient: 60% <a href="#">Coinsurance</a> Inpatient: 60% <a href="#">Coinsurance</a>	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				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.
	<a href="#">Habilitation services</a>	Outpatient: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply Inpatient: 50% <a href="#">Coinsurance</a>	Outpatient: 60% <a href="#">Coinsurance</a> Inpatient: 60% <a href="#">Coinsurance</a>	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.
	<a href="#">Skilled nursing care</a>	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Limited to 30 days per year.
	<a href="#">Durable medical equipment</a>	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
	<a href="#">Hospice services</a>	50% <a href="#">Coinsurance</a>	60% <a href="#">Coinsurance</a>	Prior authorization may be required. Covered No Limit.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Covered up to \$38.50; <a href="#">deductible</a> does not apply	Limited to 1 visit per year. <a href="#">Out-of-network provider</a> eye exam covered up to \$38.50.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Covered up to \$50; <a href="#">deductible</a> does not apply	Limited to 1 item per year. <a href="#">Out-of-network provider</a> 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 member is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Hearing aids (Limited to 1 per ear every 4 years)
- Private-duty nursing (Limited to 85 visits per 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](http://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](#) \$7,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$7,500
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,820</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,720</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,600</b>



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<b>English:</b>	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).
<b>Spanish:</b>	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).
<b>Vietnamese:</b>	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).
<b>Chinese:</b>	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)。
<b>Korean:</b>	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 연락해주시오.
<b>German:</b>	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).
<b>Arabic:</b>	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Oklahoma، ولم تكن بارعًا باللغة الإنكليزية، فلديك 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، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بخدمات الأعضاء على (1-833-492-0679 TTY 711).

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**Burmese:**

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

**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:**

ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Ambetter of Oklahoma, ແລະ ບໍ່ຊ່ຽວຊານພາສາອັງກິດ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ຖ້າຫາກທ່ານ ຫຼື ຜູ້ໃດຜູ້ໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອ, ມີສະພາບທາງການໄດ້ຍິນ ແລະ/ຫຼື ການເບິ່ງເຫັນທີ່ຂັດຂວາງການສື່ສານ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການແປພາສາ ຫຼື ບໍລິການເສີມ, ກະລຸນາຕິດຕໍ່ຫາ Member Services (ການບໍລິການສະມາຊິກ) ໄດ້ທີ່ 1-833-492-0679 (TTY 711).

