73% AV Level Silver Plan: 73% AV Level Silver Plan

Coverage Period: 01/01/2023 – 12/31/2023 Coverage for: Individual/Family | Plan Type: HMO

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://ambetter.nebraskatotalcare.com/2023-brochures.html, or call 1-833-890-0329 (TTY 711). For general definitions of common terms, such as <u>allowed amount</u>, <u>balance 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 https://www.healthcare.gov/sbc-glossary or call 1-833-890-0329 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,100 individual / \$10,200 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. Preventive care services, primary care, specialist, and urgent care office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your deductible.	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 deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$6,300 individual / \$12,600 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	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://ambetter.nebraskatotalcare.com/findadoc or call 1-833-890-0329 (TTY 711) for a list of network providers .	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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider might</u> use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before you get services</u> .
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> .

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

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	\$35 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.	
If you visit a health care provider's office or clinic	Specialist visit	\$85 Copay / visit; deductible does not apply	Not covered	Covered No Limit.	
or clinic	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	\$40 Copay / test; deductible does not apply 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	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.	
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 <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. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.	

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
More information about prescription drug coverage is available at	Preferred brand drugs (Tier 2)	Retail: \$70 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.
https://ambetter.nebra skatotalcare.com/2023	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	Mail orders are subject to 2.5x retail cost- sharing amount.
formulary.	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)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Emergency room care	50% Coinsurance	50% Coinsurance	Covered No Limit.
If you need immediate medical attention	Emergency medical transportation	50% Coinsurance	50% 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 .
	Urgent care	\$50 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
If you have a hospital	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>Copay</u> / office visit; <u>deductible</u> does not apply; 50% <u>Coinsurance</u> for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (<u>Primary Care Provider</u> (PCP) and other practitioner visits do not require prior authorization).
	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
If you are pregnant	Office visits	\$35 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery professional services	50% Coinsurance	Not covered	Prior authorization may be required. Cost- sharing does not apply for preventive	
	Childbirth/delivery facility services	50% Coinsurance	Not covered	services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 visits per year.	
	Rehabilitation services	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Per year, limited to 45 combined visits for: physical therapy, occupational therapy, speech therapy, chiropractic physiotherapy and osteopathic physiotherapy (excludes chiropractic/osteopathic manipulative adjustments). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.	
	Habilitation services	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Outpatient: Not covered Inpatient: Not covered	Outpatient: Prior authorization may be required. Per year, limited to 45 combined visits for: physical therapy, occupational therapy, speech therapy, chiropractic	

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
				physiotherapy and osteopathic physiotherapy (excludes chiropractic/osteopathic manipulative adjustments). Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)

- Infertility treatment (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.
- Private-duty nursing
- 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 (Chiropractic (or osteopathic) manipulative adjustments limited to 20 visits per year.)
- Hearing aids (Limited to \$3,000 every 48 months

 Routine foot care age 18 and under.)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Nebraska Total Care at 1-833-890-0329 (TTY 711); The Nebraska Department of Insurance PO Box 82089 Lincoln, Nebraska 68501-2089; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: The Nebraska Department of Insurance PO Box 82089 Lincoln, Nebraska 68501-2089

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-890-0329 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-890-0329 (TTY 711).

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-833-890-0329 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-890-0329 (TTY 711).

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

\$5,100
\$85
50%
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)

In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$5,100	
<u>Copayments</u>	\$500	
<u>Coinsurance</u>	\$700	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$6,360	

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

\$5,100
\$85
50%
50%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$800
Copayments	\$1,600
Coinsurance	\$0
What isn't cov	ered
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,100
■ <u>Specialist</u> <u>copayment</u>	\$85
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

This EXAMPLE event includes services like:

 $\underline{\underline{\mathsf{Emergency\ room\ care}}}\ (\mathit{including\ medical\ supplies})$

Diagnostic tests (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
	1 _,-,-,-

In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$2,500	
Copayments	\$300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	



wyuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-890-0329 (TTY 711). Viotnameso: Neu quý vi, hay nguór imá quý vi diang giúp do to do du hidi vé Ambetter from Nebraska Total Care , quý vi se có quyên duyor giúp và có idiem thóng in balan grafin quố ngữ của minh miền phí. Để nói chuyên với một thông dịch viên, xin gọi 1-833-890-0329 (TTY 711). Arabic: 対果要別一位開発事業が、接触電話・833-890-0329 (TTY 711). Arabic: がいまった はいまった はいまった はいまった いまった はいまった いまった いまった はいまった いまった いまった いまった いまった いまった いまった いまった		Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Nebraska Total Care, tiene derecho a obtener
có thém thóng tin bằng ngôn ngữ của mình mẫn phí. Để ndi chuyện với một thông dịch viên, xin gọi 1-833-890-0329 (TTY 711). Chinese: 如果您,果是您正在地球的對象,有關於 Ambetter from Nebraska Total Care 方面的問題。您有權利免費以類的母語得到機能有訊息。如果要用一位翻譯自認能,消費壓高,有過多3-890-0329 (TTY 711). Arabic: (Luxing phina) (Luxing phin	Spanish:	
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Karen:	Arabia	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from Nebraska Total Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من
解する。	Arabic:	دون أية تكلفة. للتحدث مع مترجم اتصل بـ 0329-890-871 (TTY 711).
French: droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-890-0329 (TTY 711). Isin yookan namni biraa isin deeggartan Ambetter from Nebraska Total Care irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-833-890-0329 (TTY 711) tiin bilbilaa. Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Nebraska Total Care hat, haben Sie das Recht, kosteniose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-890-0329 (TTY 711) and 한약 귀하 또는 귀하가 들고 있는 어떤 사람이 Ambetter from Nebraska Total Care 에 관해서 질문이 있다면 그리한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 관리가 있습니다. 그렇게 동역사와 애가하기 위해서는 1-833-690-0329 (TTY 711) 번으로 전화하십시오. Nepali: 대접 तपाई स्वयं वा तपाईले मद्दा गर्दै गरेको व्यक्तिसँग Ambetter from Nebraska Total Care को बारेमा प्रशहरू छन् भने तपाईसँग तपाईलाई कुने खर्च नलाग्ने गरी आपनो भाषामा मद्दा तथा जानकारी प्राप्त गर्ने अधिकार हुन्छ । दोभाषेसँग कुरा गर्नको लागि 1-833-890-0329 (TTY 711) मा फोन गर्नहोस् । B случае возникновения у вас или у лица, которому вы помогаете, какох-либо вопросов о программе страхования Ambetter from Nebraska Total Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-890-0329 (TTY 711). Laotian: ''' ''' ''' Third பழி மும் மும் மும் மும் மும் மும் மும் மும	Karen:	အသါနအ့နူစည်ေသည်သမာ်အေငသညငညပသကမူညေါကဓါနအေညသခသျအဉ် ြ သျစနဇုတငအ့ညေငညအနမစမနအနမယခ ူ1-833-890-0329 (TTY 711)
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Поговорить с переводчиком, позвоните по телефону 1-833-890-0329 (ТТҮ 711). Laotian:	Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter
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Laotian:wカコスタラグ いっか โดย บ้มีต่าใจเจ้าย. เพื่อจะเอ้ากับมายพาสา, ใช่ให 1-833-890-0329 (TTY 711).Kurdish:Ambetter from Nebraska Total Care אייני אי		поговорить с переводчиком, позвоните по телефону 1-833-890-0329 (ТТҮ 711).
שาສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທ 1-833-890-0329 (TTY 711). Kurdish: Kurdish: Ambetter from Nebraska Total Care אייני איי אי	Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Nebraska Total Care, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນ
Kurdish: (TTY 711) 1-833-890-0329 بر المعنور إليي). بنو نهو مى لمگالل و مر گئير قسه بحكيت پعيو مندى بحه المرزيگه ى ژماره تعليفونى 1-833-890-0329 (علي قسه بحكيت پعيو مندى بحه المرزيگه ى ژماره تعليفونى 1-833-890 داريد، از اين حق بر خور داريد كه كمک و اطلاعات را Persian:		ພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທ 1-833-890-0329 (TTY 711).
به رامبه (به خوْرِ ابی). بو نه ومی له گه ل و رکیر قسه بکمیت پعیو هندی بکه له رینگه ی ژماره تعلیفونی 1-833-890-0329. (TTY 711). Persian: Ambetter from Nebraska Total Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたし Japanese:	Kurdish:	نهگمر تو، بان کهسنیک که بارمهتی دهددیت پرسیاری لهسمر Ambetter from Nebraska Total Care همبوو، مافی و هرگرتنی بارمهتی و زانیاریت به زمانی خزت همیه بعبی
Persian:		بەر امبەر (بەخۇر ايى). بۇ ئەوەى لەگلەل وەرگىز قىسە بكەيت پەيوەندى بكە لەرنىگەى ژمارە تىلمفۇنى 0329-890-833-1 (TTY 711).
بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 932-890-9328) نماس بگیرید. Ambetter from Nebraska Total Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたし Japanese:	Persian:	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Nebraska Total Care دارید، از این حق برخوردارید که کمک و اطلاعات را
Japanese:		بصورت رايگان به زبان خود دريافت كنيد. براي صحبت كردن با مترجم با شماره 0329-890-833-1 (TTY 711) تماس بگيريد.
	Japanese:	Ambetter from Nebraska Total Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたし
		ます。通訳が必要な場合は、1-833-890-0329 (TTY 711) までお電話ください。

Statement of Non-Discrimination

Ambetter from Nebraska Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Nebraska Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Ambetter from Nebraska Total Care at 1-833-890-0329 (TTY 711).

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Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.