

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit

<https://ambetterofalabama.com/2023-brochures.html>, or call 1-800-442-1623 (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 1-800-442-1623 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your cost for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes, 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?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or Yes, \$3,800 individual / \$7,600 family for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these 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. 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, 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://ambetterofalabama.com/fin dadoc or call 1-800-442-1623 (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.
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 [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$45 Copay / visit	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full. Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$115 Copay / visit	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening / immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$60 Copay / test for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	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. Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET scans, MRIs)	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambetterofalabama.com/2023formulary .	Generic drugs (Tier 1)	No charge	Preferred Generic Retail: \$5 Copay / prescription Generic Retail: \$35 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Preferred brand drugs (Tier 2)	No charge	Retail: \$195 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred brand drugs (Tier 3)	No charge	Retail: \$250 Copay / prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. \$3,800 individual / \$7,600 family Rx drug deductible for non-preferred brand and specialty drugs . Cost sharing waived at non-IHCP with IHCP referral .
	Specialty drugs (Tier 4)	No charge	Retail: 50% Coinsurance ; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. \$3,800 individual / \$7,600 family Rx drug deductible for non-preferred brand and specialty drugs . Cost sharing waived at non-IHCP with IHCP referral .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need immediate medical attention	Emergency room care	No charge	\$2,500 Copay / visit (\$1250 Copay / visit for facility; \$1250	\$2,500 Copay / visit; deductible does not apply (\$1250 Copay /	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
			Copay / visit for physician fee)	visit; deductible does not apply for facility; \$1250 Copay / visit; deductible does not apply for physician fee)	
	Emergency medical transportation	No charge	50% Coinsurance	50% Coinsurance ; deductible does not apply	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider , you may be subject to balance billing . Cost sharing waived at non-IHCP with IHCP referral .
	Urgent care	No charge	\$60 Copay / visit	Not covered	Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$45 Copay / office visit; 50% Coinsurance for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner visits do not require prior authorization). Cost sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No charge	\$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	\$45 Copay / visit	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

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					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). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	No charge	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery facility services	No charge	\$3000 Copay / day	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	Outpatient: 50% Coinsurance Inpatient: \$3000 Copay / day	Not covered	Outpatient: Prior authorization may be required. Limited to 30 visits per year (combined for Outpatient Physical, Occupational, Pulmonary, Cardiac and Speech Therapy). Note: This visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 100 days per year (combined for Speech, Occupational, Pulmonary, Cardiac and Physical Therapy.) Note: This visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis. Cost sharing waived at non-IHCP with IHCP referral .
	Habilitation services	No charge	Outpatient: 50% Coinsurance Inpatient: \$3000 Copay / day	Not covered	Outpatient: Prior authorization may be required. Limited to 30 visits per year (combined for Outpatient Physical, Occupational, Pulmonary, Cardiac and Speech Therapy). Note: This visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 100 days per year (combined for Speech, Occupational,

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)	
					Pulmonary, Cardiac and Physical Therapy.) Note: This visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis. Cost sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No charge	\$3000 Copay / day	Not covered	Prior authorization may be required. Limited to 100 days per year in a facility. Cost sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Respite Care covered as part of hospice services only. 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	Not covered	Limited to 1 visit per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No charge	No charge	Not covered	Limited to 1 item per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Hearing aids • 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.) 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • 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 (Limited to 15 visits per year.)
- Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)
- 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 Alabama at 1-800-442-1623 (TTY 711); Alabama Department of Insurance, 201 Monroe St # 502, Montgomery, AL 36104; Phone: 334-269-3550; 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 [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: Alabama Department of Insurance, 201 Monroe St # 502, Montgomery, AL 36104; Phone: 334-269-3550

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 1-800-442-1623 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-442-1623 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-442-1623 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-442-1623 (TTY 711).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$115
- Hospital (facility) [copayment](#) \$3000
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$115
- Hospital (facility) [copayment](#) \$3000
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

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

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$115
- Hospital (facility) [copayment](#) \$3000
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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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.

Spanish: Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Alabama, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-442-1623 (TTY 711).

Chinese: 如果您，或是您正在協助的對象，有關於 Ambetter of Alabama 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 1-800-442-1623 (TTY 711)。

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Alabama 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-442-1623 (TTY 711) 번으로 전화하십시오.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Alabama, 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 1-800-442-1623 (TTY 711).

Arabic: إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Alabama ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-442-1623 (TTY 711).

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Alabama 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 1-800-442-1623 (TTY 711) an.

French: Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Alabama, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-800-442-1623 (TTY 711).

Gujarati: જો તમને, અથવા તમે કોઈની મદદ કરી રહ્યાં હોવ તેમને, Ambetter of Alabama વિશે કોઈ પ્રશ્નો હોય તો, તમને કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1-800-442-1623 (TTY 711) ઉપર કોલ કરો.

Tagalog: Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter of Alabama, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-442-1623 (TTY 711).

Hindi: आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of Alabama के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-800-442-1623 (TTY 711) पर कॉल करें।

Laotian: ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter of Alabama, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໃຫ້ຫາ 1-800-442-1623 (TTY 711).

Russian: В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of Alabama вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-800-442-1623 (TTY 711).

Portuguese: Se você ou alguém que estiver a ajudar tiver dúvidas sobre a Ambetter of Alabama, tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para 1-800-442-1623 (TTY 711).

Turkish: Yardım etmekte olduğunuz kişinin veya sizin Ambetter of Alabama hakkında sorularınız olursa, kendi dilinizde ücretsiz olarak bilgi ve yardım alma hakkına sahipsiniz. Bir tercümanla konuşmak için şu numarayı arayınız: 1-800-442-1623 (TTY 711).

Japanese: Ambetter of Alabama 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、1-800-442-1623 (TTY 711) までお電話ください。

Statement of Non-Discrimination

Ambetter of Alabama 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 Alabama does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter of Alabama:

- 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 Alabama at 1-800-442-1623 (TTY 711)

If you believe that Ambetter of Alabama 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 Alabama, Grievance & Appeals Department, PO Box 10341 Van Nuys, CA 91410. 1-800-442-1623 (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 Alabama is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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