



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://ambetter.nebraskatotalcare.com/2023-brochures.html>, or call 1-833-890-0329 (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 1-833-890-0329 (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 costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes.	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> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://ambetter.nebraskatotalcare.com/findadoc or call 1-833-890-0329 (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> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least)	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	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full.
	Specialist visit	No charge	Not covered	Covered No Limit.
	Preventive care/screening/immunization	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 for laboratory & professional services No charge for x-ray & diagnostic imaging No charge 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)	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ambetter.nebrasikatotalcare.com/2023formulary .	Generic drugs (Tier 1)	Preferred Generic Retail: No charge Generic Retail: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Preferred brand drugs (Tier 2)	Retail: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Non-preferred brand drugs (Tier 3)	Retail: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Specialty drugs (Tier 4)	Retail: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least)	Non-IHCP Out-Of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	No charge	No charge; deductible does not apply	Covered No Limit.
	Emergency medical transportation	No charge	No charge; 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 .
	Urgent care	No charge	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner visits do not require prior authorization).
	Inpatient services	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	No charge	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

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		Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least)	Non-IHCP Out-Of-Network Provider (You will pay the most)	
				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	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).
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization may be required. Limited to 60 visits per year.
	Rehabilitation services	Outpatient: No charge; Inpatient: No charge	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: No charge Inpatient: No charge	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 physiotherapy and osteopathic physiotherapy (excludes chiropractic/osteopathic manipulative adjustments). Note: Habilitation

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) & Non-IHCP In-Network Provider (You will pay the least)	Non-IHCP Out-Of-Network Provider (You will pay the most)	
				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	No charge	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	No charge	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	No charge	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	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 .)		
<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 • Dental care (Adult) 	<ul style="list-style-type: none"> • 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.) 	<ul style="list-style-type: none"> • 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 age 18 and under.)
- 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 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 [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: 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 [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 1-833-890-0329 (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, kwijigo holne' 1-833-890-0329 (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 coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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 coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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 coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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

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.

Ambetter from Nebraska Total Care:

- 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).

If you believe that Ambetter from Nebraska Total Care 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 from Nebraska Total Care, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-890-0329 (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 from Nebraska Total Care 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>.