# Ambetter from Nebraska Total Care
# Elite Gold + Vision + Adult Dental: Standard Gold Off Exchange Plan

**Coverage for: Individual/Family | Plan Type: HMO**

**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 deductible?** | $0 individual / $0 family. | See the Common Medical Events chart below for your cost for services this plan covers. |
| **Are there services covered before you meet your deductible?** | There is no deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers: $5,000 individual / $10,000 family. Not applicable for out-of-network providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | 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 | $5 Copay | Not covered | Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full. |
| | Specialist visit | $60 Copay | 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) | $40 Copay for laboratory & professional services<br><br>$75 Copay for x-ray & diagnostic imaging<br><br>$200 Copay 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.<br><br>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) | $75 Copay | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **https://ambetter.nebraskatotalcare.com/2023formulary**. | Generic drugs (Tier 1) | Preferred Generic Retail: $5 Copay / prescription<br><br>Generic Retail: $15 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. |
| | Preferred brand drugs (Tier 2) | Retail: $50 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. |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% Coinsurance | Not covered | |

| 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) | |
| | 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 surgery** | Facility fee (e.g., ambulatory surgery center) | $200 Copay | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | $200 Copay | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need immediate medical attention** | Emergency room care | 30% Coinsurance | 30% Coinsurance; deductible does not apply | Covered No Limit. |
| | Emergency medical transportation | 30% Coinsurance | 30% 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. |
| | Urgent care | $35 Copay | Not covered | Covered No Limit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $5 Copay / office visit; $200 Copay 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). |
| | Inpatient services | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| **If you are pregnant** | Office visits | $5 Copay | 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 |

| 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) | |
| | | | | 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 | 30% Coinsurance | 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 | 30% Coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% Coinsurance | Not covered | Prior authorization may be required. Limited to 60 visits per year. |
| | Rehabilitation services | Outpatient: $50 Copay<br>Inpatient: 30% 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 Copay<br>Inpatient: 30% Coinsurance | Outpatient: Not covered<br>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 therapy 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. Covered No Limit. |
| | Skilled nursing care | 30% Coinsurance | Not covered | Prior authorization may be required. Limited to 60 days per year. |
| | Durable medical equipment | 30% Coinsurance | Not covered | Prior authorization may be required. Covered No Limit. |
| | Hospice services | 30% 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 | 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.)**

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- 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
- 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.)
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)
- Hearing aids (Limited to $3,000 every 48 months age 18 and under.)
- 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 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, kwiijigo 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 copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $600 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,160** |

### 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 | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,320** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,100** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

| | |
|---|---|
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Nebraska Total Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-890-0329 (TTY 711). |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Nebraska Total Care , 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 1-833-890-0329 (TTY 711). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Nebraska Total Care 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 1-833-890-0329 (TTY 711)。 |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from Nebraska Total Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-890-0329 (TTY 711). |
| **Karen:** | ်ပသကယသမျှသာ်နသညနှပသကမေနှနှစဉ်ညြ်လေနဆကနျှအငသညျဘေသကအ Ambetter from Nebraska Total Care, ပသကှ့လေနအှ့နမဝါ့အ အသါနအှ့နှစဉ်ညြ်သမာ်အေငသညငညပသကမူညြ်ကါ်နအေညသခသျှအဉ် ၊ သျှစနဒုတငအ့ှ့ညေငညအနမစမနအနမယခဋ1-833-890-0329 (TTY 711) |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Nebraska Total Care, vous avez le 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). |
| **Cushite:** | 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. |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Nebraska Total Care 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 1-833-890-0329 (TTY 711) an. |
| **Korean:** | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Nebraska Total Care 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-890-0329 (TTY 711)번으로 전화하십시오. |
| **Nepali:** | यदि तपाईं स्वयं वा तपाईंले मद्दत गर्दै गरेको व्यक्तिसँग Ambetter from Nebraska Total Care को बारेमा प्रश्नहरू छन् भने तपाईंसँग तपाईंलाई कुनै खर्च नलाग्ने गरी आफ्नो भाषामा मद्दत तथा जानकारी प्राप्त गर्ने अधिकार हुन्छ । दोभाषेसँग कुरा गर्नको लागि 1-833-890-0329 (TTY 711) मा फोन गर्नुहोस् । |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-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:** | ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Nebraska Total Care, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າใช้จ่าย. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທ 1-833-890-0329 (TTY 711). |
| **Kurdish:** | ئەگەر تۆ، یان کەسێک کە یارمەتی دەدەیت پرسیاری لەسەر Ambetter from Nebraska Total Care هەبوو، مافی وەرگرتنی یارمەتی و زانیاریت بە زمانی خۆت هەیە بەبێ بەرامبەر(بەخۆڕایی). بۆ ئەوەی لەگەڵ وەرگێڕ قسە بکەیت پەیوەندی بکە لەرێگەی ژمارە تەلەفۆنی 1-833-890-0329 (TTY 711). |
| **Persian:** | اگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد Ambetter from Nebraska Total Care دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره 1-833-890-0329 (TTY 711) تماس بگیرید. |
| **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.

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*.