Ambetter from Absolute Total Care
Complete Gold + Vision + Adult Dental: Standard Gold Off Exchange Plan

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.absolutetotalcare.com/2023-brochures.html, or call 1-833-270-5443 (Relay 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 1-833-270-5443 (Relay 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,450 individual / $2,900 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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 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: $7,500 individual / $15,000 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.absolutetotalcare.com/findadoc or call 1-833-	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

	270-5443 (Relay 711) for a list of network providers.	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	$15 Copay / visit; deductible 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.
	Specialist visit	$35 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
	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 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)	$15 Copay / test; deductible does not apply for laboratory & professional services 20% Coinsurance for x-ray & diagnostic imaging 20% 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)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambetter.absolutetotalcare.com/2023formulary**.	Generic drugs (Tier 1)	Preferred Generic Retail: $5 Copay / prescription; deductible does not apply Generic Retail: $15 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. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $30 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. Mail orders are subject to 2.5x retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	Retail: 30% Coinsurance	Not covered	
	Specialty drugs (Tier 4)	Retail: 30% 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)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Covered No Limit.
	Emergency medical transportation	20% Coinsurance	20% 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	$35 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copay / office visit; deductible does not apply; 20% 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).
	Inpatient services	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$15 Copay / visit; deductible 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	20% 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	20% Coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Rehabilitation services	Outpatient: 20% Coinsurance Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 30 visits per year per therapy (occupational, physical and speech therapy); no limit applies for cardiac or pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: 20% Coinsurance Inpatient: 20% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Limited to 30 visits per year per therapy (occupational, physical and speech therapy); no limit applies for cardiac or pulmonary therapy. 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	20% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Respite Care covered as part of hospice services only.
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
- Hearing aids
- Infertility treatment (Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

- Dental (Children)
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)

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

- Chiropractic care
- 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 from Absolute Total Care at 1-833-270-5443 (Relay 711); South Carolina Department of Insurance, PO Box 100105, Columbia, SC 29202, Phone No. 1-803-737-6180 or 1-800-768-3467.; 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 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: South Carolina Department of Insurance, PO Box 100105, Columbia, SC 29202, Phone No. 1-803-737-6180 or 1-800-768-3467.

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 1-833-270-5443 (Relay 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-270-5443 (Relay 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-270-5443 (Relay 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-270-5443 (Relay 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	$1,450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,450
Copayments	$300
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,310**

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

The plan's overall deductible	$1,450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$1,450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,450
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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 Absolute Total Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-270-5443 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Absolute 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 1-833-270-5443 (Relay 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Absolute 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 1-833-270-5443 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Absolute Total Care,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는[1-833-270-5443 (Relay 711) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos Ambetter from Absolute Total Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-270-5443 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Absolute Total Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag 1-833-270-5443 (Relay 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Absolute Total Care, вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-270-5443 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Absolute 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 1-833-270-5443 (Relay 711) an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Absolute Total Care, વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-270-5443 (Relay 711) ઉપર કૉલ કરો.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Absolute Total Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-270-5443 (Relay 711).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Absolute Total Care, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-833-270-5443 (Relay 711).
Japanese:	Ambetter from Absolute 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、1-833-270-5443 (Relay 711) までお電話ください。
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Absolute Total Care ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-833-270-5443 (Relay 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711) पर कॉल करें।
Mon-Khmer, Cambodian:	ប្រសិនលោកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានបញ្ហាអំពី Ambetter from Absolute Total Care អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសាលោកអ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែតាមលេខ 1-833-270-5443 (Relay 711).

Statement of Non-Discrimination

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

Ambetter from Absolute 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 Absolute Total Care at 1-833-270-5443 (Relay 711).

If you believe that Ambetter from Absolute 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 Absolute Total Care, ATTN: Ambetter Grievances and Appeals Department, PO Box 10341 Van Nuys CA, 91410, 1-833-270-5443 (Relay 711), Fax: 1-833-886-7956. You can file a grievance by mail or fax. If you need help filing a grievance, Ambetter from Absolute 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.*