It is your responsibility to pay any copays, coinsurance or deductible related to any non-essential health benefit despite any participation in a federal or state government run program that offers subsidies or premium assistance. Payments related to non-essential health benefits will not count toward the maximum out of pocket benefit.

Ambetter Balanced Care 2 - 94% AV Cost Sharing		
Benefit	**Insured Responsibility(per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$150 Individual $300 Family	$6,000 Individual $12,000 Family
Prescription Drug Deductible per Calendar Year	$0 Individual $0 Family	Not Covered
Coinsurance For All Other Eligible Expenses	0% Coinsurance	50% Coinsurance
Out-Of-Pocket Maximum per Calendar Year	$754 Individual $1,508 Family	$12,500 Individual $25,000 Family
Physician Office Services		
Primary Care Physician Office Visit	$8 Copayment	50% Coinsurance
Specialist Physician Office Visit*	$10 Copayment	50% Coinsurance
Other Practitioner Office Visit	$4 Copayment	50% Coinsurance
Preventive Care (including screenings, immunizations and well-baby visits)	0% Coinsurance	50% Coinsurance
Diagnostic Test (x-ray and lab-work)*	$0 Copayment	50% Coinsurance
Imaging Test (CT/PET scans, MRI)*	$0 Copayment	50% Coinsurance
Prescription Drugs		
Generic	$4 Copayment	Not Covered
Preferred Brand*	$4 Copayment	Not Covered
Non-Preferred Brand* • $0 Prescription Drug Deductible combined with Specialty	$8 Copayment after Prescription Drug Deductible	Not Covered
Specialty* • $0 Prescription Drug Deductible combined with Non-Preferred	$8 Copayment after Prescription Drug Deductible	Not Covered
Mail Order (90 day supply)	3 Times Retail Cost Sharing	Not Covered
Outpatient Services		
Outpatient Facility	9% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services*	9% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	$0 Copayment	50% Coinsurance
Emergency and Urgent Care Services		
Emergency Room	$0 Copayment	$0 Copayment
Emergency Transportation/Ambulance (Air* or Ground)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Urgent Care	$10 Copayment	50% Coinsurance
Inpatient Hospital Services*		
Inpatient Hospital Facility*	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Inpatient Hospital Physician and Surgical Services*	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment*		
Mental/Behavioral Health Outpatient Services*	$4 Copayment	50% Coinsurance

Mental/Behavioral Health Inpatient Services*	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Substance Use Disorder Outpatient Services*	$4 Copayment	50% Coinsurance
Substance Use Disorder Inpatient Services*	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Maternity and Newborn Care		
Prenatal and Postnatal Care*	$8 Copayment	50% Coinsurance
Delivery and Inpatient Services*	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Other Covered Services		
Home Health Care Services* 50 visits per year	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy) (Prior Authorization required for in home services)* 30 visits per year	$4 Copayment	50% Coinsurance
Inpatient Rehabilitation* 60 visits per year	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Neurological Rehabilitation* Limited to 60 days per lifetime	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Habilitation Services* 30 visits per year 180 hours per year for developmental services	$4 Copayment	50% Coinsurance
Skilled Nursing Facility* 60 visits per year	$20 Copayment per day after Deductible	50% Coinsurance after Deductible
Durable Medical Equipment *	$4 Copayment	50% Coinsurance
Hospice Services*	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Care (Prior Authorization required for in home services)* 30 visits per year	$10 Copayment	50% Coinsurance
Transplant Benefit*	$140 Copayment per day after Deductible	50% Coinsurance after Deductible
Diabetes Care Management*	$4 Copayment	50% Coinsurance
Hearing Aids* 1 pair per year	0% Coinsurance	50% Coinsurance
Vision Services – Pediatric (Up to 19 years of age)		
Copayment for Exams	$10 Copayment	$20 Copayment
Copayment for Eyewear	$4 Copayment	$20 Copayment
Routine Eye Exam 1 visit per year	100% Covered after Copayment	Covered up to $38.50 after Copayment
Eyeglasses (frames) and contacts 1 item per year	100% Covered after Copayment	Covered up to $50 after Copayment
Lenses (per pair)		
• Single	100% Covered after Copayment	Covered up to $37.50 after Copayment
• Bifocal	100% Covered after Copayment	Covered up to $55 after Copayment
• Trifocal	100% Covered after Copayment	Covered up to $75 after Copayment
• Lenticular	100% Covered after Copayment	Covered up to $75 after Copayment

Contact Lenses		
• Contact lenses (in lieu of glasses)	100% Covered after Copayment	Covered up to $91 after Copayment
• Contact Lens Fitting	100% Covered after Copayment	Covered up to $26.60 after Copayment
• Specialty Lens Fitting	100% Covered after Copayment	Covered up to $35 after Copayment

Wellness Programs; Disease or Case Management Programs; Other Programs $25 to $250

The benefit available for participation in a wellness program, a disease or case management program or another program will usually be in the form of a credit added to a debit card we issue to the member and, depending on the particular program, is usually between $25 and $250. Such credits may be one-time rewards, available periodically or related to specific requirements under a particular program. Discounts also may be available for participating in a program. You may obtain information regarding the available programs, the requirements for participation in each program and the benefits available for participating in a particular program by visiting our website at http://ambetter.ambetterofarkansas.com/ or by contacting Member Services by telephone at 1-877-617-0390.