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.arhealthwellness.com/2019-brochures, or call 1-877-617-0390, TTY/TDD 1-877-617-0392. 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 1-877-617-0390, TTY/TDD 1-877-617-0392 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $5,100 individual / $10,200 family. Non-network providers: $10,200 individual/$20,400 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, imaging, diagnostic tests, 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?	Yes, $1,000 individual / $2,000 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $6,450 individual/$12,900 family. For non-network providers: $12,900 individual/$25,800 family.	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 http://ambetter.arhealthwellness.com/findadoc or call 1-877-617-0390 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	$50 Copay/visit; deductible does not apply	50% Coinsurance; deductible does not apply	-----None-----
	Specialist visit	$75 Copay/visit; deductible does not apply	50% Coinsurance; deductible does not apply	-----None-----
	Preventive care/screening/ immunization	No charge	50% Coinsurance; deductible does not apply	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)	$50 Copay/test; deductible does not apply	50% Coinsurance; deductible does not apply	Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	$150 Copay/test; deductible does not apply	50% Coinsurance; deductible does not apply	Prior authorization may be required.

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 www.http://ambetter.arhealthwellness.com/2019formulary	Generic drugs (Tier 1)	Retail: $10 Copay/prescription; Mail Order: $30 Copay/prescription; deductible does not apply	Not covered	Prescription drugs are provided for up to 31 days retail and up to 90 days mail order. Mail orders are subject to 3x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $50 Copay/prescription; Mail Order: $150 Copay/prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	Retail: $100 Copay/prescription; Mail Order: $300 Copay/prescription; subject to Rx drug deductible	Not covered	Prior authorization may be required. $1,000 individual / $2,000 family Rx drug deductible for non-preferred brand and specialty drugs. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail cost-sharing amount.
	Specialty drugs (Tier 4)	Retail: $250 Copay/prescription; Mail Order: $750 Copay/prescription; subject to Rx drug deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Prior authorization may be required.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	$250 Copay/visit	$250 Copay/visit	-----None-----
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	-----None-----
	Urgent care	$100 Copay/visit; deductible does not apply	50% Coinsurance; deductible does not apply	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 Copay per day	50% Coinsurance	Prior authorization may be required.
	Physician/surgeon fees	$300 Copay per stay	50% Coinsurance	Prior authorization may be required.

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	$50 Copay/office visit; deductible does not apply; no charge for other outpatient services	50% Coinsurance; deductible does not apply	Prior authorization may be required. (PCP and Other Practitioner visits do not require prior authorization)
	Inpatient services	$1,000 Copay per day	50% Coinsurance	Prior authorization may be required.
If you are pregnant	Office visits	$50 Copay/visit, deductible does not apply	50% Coinsurance; deductible does not apply	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. 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	$300 Copay per stay	50% Coinsurance	
	Childbirth/delivery facility services	$1,000 Copay per day	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Prior authorization may be required. 50 Visits per year.
	Rehabilitation services	$50 Copay/visit; deductible does not apply	50% Coinsurance; deductible does not apply	Combined 30 visit limit per year for PT, OT, ST and chiropractic care.
	Habilitation services	$50 Copay/visit; deductible does not apply	50% Coinsurance; deductible does not apply	30 Visits per year for outpatient habilitative services. 180 visits per year for developmental services.
	Skilled nursing care	$100 Copay per day	50% Coinsurance	Prior authorization may be required. 60 days per year in a facility.
	Durable medical equipment	$50 Copay/item; deductible does not apply	50% Coinsurance; deductible does not apply	Prior authorization may be required.
	Hospice services	20% Coinsurance	50% Coinsurance	Prior authorization may be required. Benefits for hospice inpatient, home or outpatient care are available to a terminally ill covered person for one continuous period up to 180 days in a covered person's lifetime.
If your child needs	Children's eye exam	No charge	No charge	1 Visit per year. Out-of-network provider eye

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)	
dental or eye care				exam covered up to $38.50.
	Children's glasses	No charge	No charge	1 Item per year. Out-of-network provider frames or contacts covered up to $50, see schedule for lens limit.
	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
- Long-term care
- 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 (Limited to 30 specialist visits per year combined with speech, physical and occupational therapy)
- Hearing aids (Limited to one pair every three years)
- Infertility treatment (See policy for coverage details)
- Routine foot care (For diabetes treatment)

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 Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392); Arkansas Insurance Department, 1200 West Third Street Little Rock, AR 72201-1904, Phone No. 1-501-371-2600 or 1-800-282-9134 Fax No. 1-800-852-5494 Seniors No. 1-800-224-6330. 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 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: Arkansas Insurance Department, 1200 West Third Street Little Rock, AR 72201-1904, Phone No. 1-501-371-2600 or 1-800-282-9134 Fax No. 1-800-852-5494 Seniors No. 1-800-224-6330. Additionally, a consumer assistance program can help you file your appeal. Contact 1-855-332-2227 or 1-501-371-2645.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
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 1-877-617-0390, TTY/TDD 1-877-617-0392.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-617-0390, TTY/TDD 1-877-617-0392.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-617-0390, TTY/TDD 1-877-617-0392.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-617-0390, TTY/TDD 1-877-617-0392.

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	$5,100
Specialist copayment	$75
Hospital (facility) copayment	$1,000
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$3,850
Copayments	$2,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,510**

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

The plan's overall deductible	$5,100
Specialist copayment	$75
Hospital (facility) copayment	$1,000
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$2,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,060**

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

The plan's overall deductible	$5,100
Specialist copayment	$75
Hospital (facility) copayment	$1,000
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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