




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/2022-brochures.html>, 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 : \$5,450 Individual / \$10,900 Family. Out-of-network providers : \$7,500 Individual / \$15,000 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 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 : \$8,100 Individual / \$16,200 Family. For out-of-network providers : \$12,500 Individual / \$25,000 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 https://ambetter.arhealthwellness.com/findadoc or call 1-877-617-0390 (TTY/TDD 1-877-617-0392) 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 .
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 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	\$25 Copay / visit; deductible does not apply	60% Coinsurance ; deductible does not apply	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.
	Specialist visit	\$50 Copay / visit; deductible does not apply	60% Coinsurance ; deductible does not apply	Covered No Limit.
	Preventive care/screening/immunization	No charge; deductible does not apply	60% 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)	\$25 Copay / test; deductible does not apply for laboratory & professional services	60% Coinsurance ; deductible does not apply for laboratory & professional services	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.
		30% Coinsurance for x-ray & diagnostic imaging	60% Coinsurance for x-ray & diagnostic imaging	
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 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.

*For more information about limitations and exceptions, see [plan](#) or policy document at <https://api.centene.com/eoc/2022/70525AR007.pdf>.

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)	
More information about prescription drug coverage is available at https://ambetter.arhealthwellness.com/2022formulary .		deductible does not apply Generic Retail: \$25 Copay / prescription; deductible does not apply		Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: \$50 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.
	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	Mail orders are subject to 2.5x retail cost-sharing amount.
	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)	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	30% Coinsurance	30% Coinsurance	Covered No Limit.
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization
	Urgent care	\$60 Copay / visit; deductible does not apply	60% Coinsurance ; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	30% Coinsurance	60% Coinsurance	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	\$25 Copay /Office Visit (deductible does not apply); 30% Coinsurance for other outpatient services	60% Coinsurance /Office Visit (deductible does not apply); 60% Coinsurance for other outpatient services	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$25 Copay / visit; deductible does not apply	60% 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 , 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	30% Coinsurance	60% Coinsurance	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	60% Coinsurance	Prior authorization may be required. Limited to 50 visits per year.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to a combined 30 visit limit per year for outpatient physical therapy, speech therapy, occupational therapy and chiropractic care. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Rehabilitation services	30% Coinsurance	60% Coinsurance	

*For more information about limitations and exceptions, see [plan](#) or policy document at <https://api.centene.com/eoc/2022/70525AR007.pdf>.

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)	
	Habilitation services	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to a combined 30 visit limit per year for outpatient habilitation services; limited to 180 visits per year for developmental services. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	30% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Covered up to \$38.50; deductible does not apply	Limited to 1 visit per year. Out-of-network provider eye exam covered up to \$38.50.
	Children's glasses	No charge; deductible does not apply	Covered up to \$50; deductible does not apply	Limited to 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 .)		
<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 	<ul style="list-style-type: none"> Dental care Infertility treatment 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

*For more information about limitations and exceptions, see [plan](#) or policy document at <https://api.centene.com/eoc/2022/70525AR007.pdf>.

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

- Chiropractic care (Limited to a combined 30 visit limit per year (combined for chiropractic care, physical therapy, speech therapy and occupational therapy).)
- Hearing aids (Limited to 1 pair every 3 years.)
- Routine foot care (Coverage is limited to diabetes care only.)

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 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: 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 (501) 371-2645.

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 1-877-617-0390 (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, kwijigo 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	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)	
Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,450
Copayments	\$400
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,910

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)	
Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$5,450
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700