Ambetter from Arkansas Health & Wellness

Connected Silver (QualChoiceLife) - 94% AV Level Silver Plan 41% - 60% FPL: 94% AV Level Silver 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.arhealthwellness.com/2023-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?	$0	See the Common Medical Events chart below for your costs 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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
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.

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	No charge; deductible does not apply	No charge; deductible does not apply	Covered No Limit.
	Specialist visit	No charge; deductible does not apply	No charge; deductible does not apply	Covered No Limit.
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; 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)	No charge; deductible does not apply for laboratory & professional services No charge; deductible does not apply for x-ray & diagnostic imaging No charge; deductible does not apply for laboratory & professional services and x-ray & diagnostic imaging at other places of service	No charge; deductible does not apply for laboratory & professional services No charge; deductible does not apply for x-ray & diagnostic imaging No charge; deductible does not apply for laboratory & professional services and x-ray & diagnostic imaging at other places of service	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)	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail: No charge; 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.
	Preferred brand drugs (Tier 2)	Retail: No charge; 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: No charge; deductible does not apply	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)	
More information about **prescription drug coverage** is available at **https://ambetter.arhealthwellness.com/2023formulary**.	Specialty drugs (Tier 4)	Retail: No charge; deductible does not apply	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)	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	No charge; deductible does not apply	No charge; deductible does not apply	Covered No Limit.
	Emergency medical transportation	No charge; deductible does not apply	No charge; 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	No charge; deductible does not apply	No charge; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner visits do not require prior authorization).
	Inpatient services	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization not required for deliveries within the standard timeframe per federal

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)	
				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	No charge; deductible does not apply	No charge; deductible does not apply	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	No charge; deductible does not apply	No charge; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Limited to 50 visits per year.
	Rehabilitation services	Outpatient: No charge; deductible does not apply Inpatient: No charge; deductible does not apply	Outpatient: No charge; deductible does not apply Inpatient: No charge; deductible does not apply	Outpatient: 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. Inpatient: Prior authorization may be required. Limited to 60 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	Outpatient: No charge; deductible does not apply Inpatient: No charge; deductible does not apply	Outpatient: No charge; deductible does not apply Inpatient: No charge; deductible does not apply	Outpatient: 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

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)	
				therapy limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Limited to 60 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	Prior authorization may be required. Covered No Limit. Respite Care available in conjunction with hospice care. Limited to 14 days per year.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 visit per year.
	Children's glasses	No charge	No charge	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 when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- 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
- 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 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.)
- Infertility treatment (Coverage includes testing to diagnose infertility, infertility counseling and planning services; also, in vitro fertilization procedures are covered.)
- 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 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, 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	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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 coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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