Ambetter from Arkansas Health & Wellness
Everyday Gold + Vision + Adult Dental: Standard Gold On 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.arhealthwellness.com/2024-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: $750 Individual / $1,500 Family. Out-of-network providers: $2,500 Individual / $5,000 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 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. For out-of-network providers: $8,700 Individual / $17,400 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-

Important Questions	Answers	Why This Matters:
		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	$35 Copay / visit; deductible does not apply	50% Coinsurance; deductible does not apply	Covered No Limit.
	Specialist visit	$55 Copay / visit; deductible does not apply	50% Coinsurance; deductible does not apply	Covered No Limit.
	Preventive care/screening/ immunization	No charge; deductible does not apply	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)	$35 Copay / visit; deductible does not apply for laboratory & professional services 35% Coinsurance for x-ray & diagnostic imaging 35% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	50% Coinsurance; deductible does not apply for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance 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.
	Imaging (CT/PET scans, MRIs)	35% Coinsurance	50% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://ambetter.arhealthwellness.com/2024formulary**.	Generic drugs (Tier 1)	Preferred Generic Retail: $3 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: $60 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: 50% Coinsurance	Not covered	
	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)	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	35% Coinsurance	35% Coinsurance	Covered No Limit.
	Emergency medical transportation	35% Coinsurance	35% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	$35 Copay / visit; deductible does not apply	50% Coinsurance; deductible does not apply	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 Copay / visit; deductible does not apply;	Office Visit: 50% Coinsurance; deductible does not apply;	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)

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)	
		Other Outpatient Services: 35% Coinsurance Note: Cost share will be waived for Behavioral Health screening services.	Other Outpatient Services: 50% Coinsurance Note: Cost share will be waived for Behavioral Health screening services.	
	Inpatient services	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$35 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, 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	35% Coinsurance	50% 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	35% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Limited to 50 visits per year.
	Rehabilitation services	Outpatient: 35% Coinsurance Inpatient: 35% Coinsurance	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	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

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)	
				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: 35% Coinsurance Inpatient: 35% Coinsurance	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	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: 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	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Limited to 60 days per year.
	Durable medical equipment	35% Coinsurance	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Hospice services	35% Coinsurance	50% 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.)

- Abortion (Except in cases when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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))
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)
- Hearing aids (Limited to 1 pair every 3 years.)
- Infertility treatment
- 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 Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392); Arkansas Insurance Department, 1 Commerce Way, Little Rock, AR 72202, Phone No. 800-282-9134 or 501-371-2600 Fax Number 501-371-2618 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, 1 Commerce Way, Little Rock, AR 72202, Phone No. 800-282-9134 or 501-371-2600 Fax Number 501-371-2618 Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-282-9134 or (501) 371-2600.

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	$750
Specialist copayment	$55
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$750
Copayments	$500
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,110**

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

The plan's overall deductible	$750
Specialist copayment	$55
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$750
Copayments	$1,400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,180**

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

The plan's overall deductible	$750
Specialist copayment	$55
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$750
Copayments	$200
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

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