



A Guide to Out-of- Pocket Costs



Health Insurance the Arkansas Way.

There are two types of costs that you pay for health insurance: your monthly payment that you make no matter what, called a premium, and costs you pay at the point of care, called out-of-pocket costs.

Out-of-pocket costs can be confusing, and each plan contains a different mix of costs. It's important to understand these terms to pick the best plan for you and your family.

Deductible

Each insurance plan sets an amount that you pay for covered health care services before insurance starts to pay, called a deductible. After you pay your deductible, you generally only pay co-pays or coinsurance for covered services and your insurance pays the rest.

Plans with lower premiums often have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Other important information about deductibles includes :

- All Marketplace health insurance plans pay the full cost of certain preventive health care services even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Many plans pay for certain services, like checkups or disease management, before you've met your deductible.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Copayment or Co-Pay

Co-pays are fixed amounts that you pay for covered services any time you receive medical services. For example, if your copayment for a doctor's visit is \$35 and your allowed amount (negotiated with the insurance company) for the services rendered is \$75, then you will pay \$35 and the insurance carrier will pay the rest.

In some cases, the copayments vary for different services within the same plan, i.e. drugs, lab tests, visits to specialists, etc.

Coinsurance

Coinsurance is the percentage of cost of a covered service that you pay after you've paid your deductible. Most plans have a mix of co-pays and coinsurance.

For example, if your same plan has a 20% coinsurance on the allowed amount, which is the maximum amount your plan sets for point of service, of \$75:

- If you've paid your deductible: You pay 20% of the \$75 (or \$15) and your insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, which is \$75.

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- **Online** – Visit myARinsurance.com for more information
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Paying for Health Insurance: What You Need to Know



You can choose a plan from a top-rated insurance company. You may qualify for help to lower the cost.

Did you know? Plans on the Marketplace come from top-rated insurance companies. They cover the same thing as group plans through employers. What's the difference? With a plan from the Marketplace, you may be able to get help with the cost.

There are two forms of help to lower the cost:

- Premium (monthly cost) tax credit
- Cost sharing reduction

How Premium Tax Credits Work

They lower the cost of a plan. Two ways to use the credit:

- **Take it now:**
 - It lowers your premium
 - It is paid to your plan each month
 - When you file taxes, report that you already used the credit
- **Take it later:**
 - You pay the full premium each month
 - When you file taxes, subtract the credit from any tax you owe
 - If you don't owe tax, you get a bigger refund

How Cost Sharing Reductions Work

- Reduces deductibles, coinsurance and co-pays
- Find out if you qualify

Get peace of mind for you and your family.

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A Guide to Provider Networks



While the Marketplace groups plans by price, it's important to make sure that the plan you choose includes the doctors you want to see in its provider network.

What is a Provider?

Provider is a term for doctor or health professional or anyone you see for health care – including nurses, nurse practitioners, physical therapists and more. Insurance plans categorize providers two ways:

- **Regular Provider:** A doctor or other health care professional who provides general medicine services.
- **Specialist:** A provider who focuses on a specific area or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care. Examples include oncologists (cancer doctors) or physical therapists.

What is a Provider Network?

A provider network is a list of doctors and is determined by the insurance company and plan. Each plan has a different provider network, and provider networks may also be different between different plans offered by the same insurance company.

Plan Types and Provider Networks

You should always call your insurance company, or any insurance company you are looking to buy from, to make sure your doctor is in network. Plan types, designated by abbreviated names, can tell you a little bit about how open your plan is.

- **Exclusive Provider Organization (EPO):** Generally, services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).
- **Health Maintenance Organization (HMO):** Generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
- **Point of Service (POS):** A type of plan where you pay less if you use doctors, hospitals, and other health care providers who belong to the plan's network. POS plans require you to get a referral from your primary care doctor (a designated doctor you pick who is in charge of managing your care) in order to see a specialist.
- **Preferred Provider Organization (PPO):** Generally, you pay less if you use providers in the plan's network. For an additional cost, you can use doctors, hospitals, and providers outside the network without a referral.

A Guide to Picking the Right Plan

It's important that you take both cost and network into account when you pick your plan. Use this checklist to make sure your doctor is in network.

- Find a plan that has a good balance of premium and out-of-pocket costs for your family.
- Identify your health needs and make sure your potential plan has hospitals, doctors' offices, and other places for care near you.
- Look up your plan's provider network online and make sure your current doctors or hospitals are covered.
- Call the insurance company and confirm that your current doctors and hospitals are covered.

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Health Coverage Options for Young Adults



Health Insurance the Arkansas Way.

Now, young adults can stay on their parents' health plans until they turn 26. After your 26th birthday, you'll need to get your own plan through your employer, the Marketplace, or Arkansas Works if you qualify. Below are frequently asked questions to help you enroll.

How Long Do I Have to Enroll?

Turning 26 qualifies you for what is called a "Special Enrollment Period," which means that you can buy coverage through the Marketplace outside of open enrollment. You have 60 days before and after your 26th birthday to enroll.

What Types of Plans Can I Choose From?

Depending on your situation, you may be eligible for help to lower the cost of insurance. Eight out of ten Arkansans qualified for health insurance in previous years. All plans through the Marketplace are from top-rated Arkansas insurance carriers and cover a comprehensive set of benefits called the "Essential Health Benefits."

You can also pick a "Catastrophic" health plan – a plan with low monthly costs, but very high deductibles, that protects you from worst-case scenarios.

If you are in school, you may also be able to enroll in a school health plan – if your school offers one – that meets the requirement for having health coverage under the law.

What Do I Need to Apply?

- Information on how you file your taxes (single, married, head of household)
- Household income you expect next year
- Information for all people you want on your plan:
 - Home and/or mailing address
 - Social security number(s)
 - Work and income info (such as pay stub, W-2 form, or wage and tax statement). For any current health insurance: the carrier and policy number
- Legal immigrants also need document information

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Understanding Plan Categories in the Marketplace



Plans in the Marketplace are grouped into four categories, called “metal levels.” Catastrophic plans, which are plans that have low monthly premiums and high deductibles where you pay most of your medical bills yourself, are also available for some people.

Decoding Metal Levels

Metal categories are grouped by the way you and your plan split the cost of health care. All plans include the same covered benefits, so these levels have nothing to do with the actual quality of care – just the cost.

Estimated Metal Category Averages

Plan Category	Percentage the Insurance Company Pays	Percentage You Pay	Premium
Bronze	60%	40%	\$
Silver	70%	30%	\$\$
Gold	80%	20%	\$\$\$

Deciding the Metal Level that Works Best for Your Family

There are two types of costs that are affected by metal levels:

- **Premium:** The amount you pay for your health insurance every month.
- **Deductible:** The amount you have to pay for covered services before your insurance starts to pay.

Bronze

- Lowest monthly premium
- Some of the highest deductibles
- Highest costs when you need care

Silver

- Moderate monthly premium
- Deductibles are usually lower than Bronze plans
- Moderate costs when you need care

Gold

- High monthly premium
- Deductibles are usually low
- Low costs when you need care

Your premium can be lower based on your income, no matter which metal category you pick. If you are an individual making between \$16,753 and \$48,560 or a family of four with a household income between \$34,638 and \$100,400, you may qualify for help to lower your monthly premium.

Understanding Catastrophic Health Plans

Some Arkansans will qualify for catastrophic health insurance, which is a plan with low monthly premiums but a very high deductible. This means that you would need to pay the entire deductible if you got sick or injured before your health plan covered any costs.

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Free Preventive Care



Preventive care plays a key role in keeping your medical costs down in the long run. When you enroll for health coverage through My Arkansas Insurance, you're guaranteed free preventive care, including regular doctor visits, cancer screenings, disease prevention screening, and the following:

- 1. Alcohol abuse screening and counseling** for kids and adults
- 2. Aspirin use** to prevent heart disease for men and women of certain ages
- 3. Autism screening** for children at 18 and 24 months
- 4. Blood pressure screening**
- 5. Cervical dysplasia screening** for sexually active adolescent females
- 6. Cholesterol screening** for adults at high risk or who are a certain age
- 7. Colorectal cancer screening** for adults over 50
- 8. Depression screening** for kids and adults
- 9. Developmental screening** for children under age 3
- 10. Diabetes (Type 2) screening** for adults with high blood pressure
- 11. Diet counseling** for adults at higher risk for chronic disease
- 12. Fluoride supplements** for children without fluoride in their water source
- 13. Height, weight and body mass index (BMI) measurements** for children
- 14. Hepatitis B screening** for people at high risk.
- 15. Hepatitis C screening** for adults at increased risk, and one time for everyone born between 1945-1965
- 16. HIV screening** for everyone ages 15-65, and other ages at increased risk
- 17. Immunization vaccines** for children from birth-18 years, and adults – doses, recommended ages, and recommended populations vary
- 18. Iron supplements** for children ages 6-12 months at risk for anemia
- 19. Lead screening** for children at risk of exposure
- 20. Lung cancer screening** for adults 55-80 at high risk for lung cancer
- 21. Newborn Screening, including:**
 - a. Phenylketonuria (PKU) screening**
 - b. Hypothyroidism screening**
 - c. Hearing screening**
 - d. Sickle Cell screening**
- 22. Obesity screening and counseling**
- 23. Oral health risk assessment** for young children
- 24. Sexually transmitted infection (STI) prevention counseling** for adolescents and adults at higher risk
- 25. Syphilis screening** for adults at higher risk
- 26. Tobacco use screening** for adults and interventions for tobacco users
- 27. TB testing** for children at higher risk of tuberculosis
- 28. Vision screening** for all children

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Health Insurance Guide for Arkansas Individuals and Families



Each year from November 1 through December 15, Arkansans can sign up for a quality health plan from a top-rated insurance company. There are plans for individuals and families. Go to myARinsurance.com.

Important facts about signing up for insurance:

- **Plans are by Arkansans for Arkansans:** Arkansans design the plans and manage the Arkansas Health Insurance Marketplace. It is a partnership of our state and HealthCare.gov.
- **You can sign up for a plan from November 1 to December 15:** This is called the Open Enrollment Period.
- **Trained experts across the state can meet with you and help you enroll:** Visit myARinsurance.com to find free help near you.
- **You may qualify for help with the monthly cost (premium):** About eight out of 10 Arkansans enrolled previously received help.
- **Certain life changes may mean you can sign up outside of Open Enrollment:** A major change like a new job, marriage, divorce or having a baby may qualify you for a Special Enrollment Period. This means that you can sign up for a plan when the change happens.

Get peace of mind for you and your family.

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All Plans Now Have Full Benefits *10 Essential Health Benefits*



All health insurance plans now must have a full set of benefits. They are called the 10 Essential Health Benefits.

All plans include:

- **Preventive care:** To prevent and control health problems, free of charge. Includes checkups, cancer screenings, help to quit smoking, and more.
- **Prescriptions:** Prescription medications a doctor orders to treat or manage an illness.
- **Outpatient care:** Care without being admitted to a hospital, like a doctor's office visit or same-day surgery. Includes home health and hospice care.
- **Emergency care:** For things that could lead to serious issues or death, like an accident or sudden illness. Can include ambulance to the ER.
- **Hospitalization:** Overnight care in a hospital.
- **Maternity and newborn care:** For pregnant women, new moms, and babies. Includes breastfeeding support.
- **Mental health and addiction care:** Care in and out of a hospital. To evaluate, diagnose (learn the cause of), and treat mental health or drug abuse problems.
- **Rehabilitative and Habilitative Services:** Care, services, and devices to help regain or gain ability. Includes services to help you regain ability, like speech therapy after a stroke. Also, services to help gain ability, like speech therapy for children.
- **Lab tests:** Tests a doctor orders to diagnose injury, illness, or condition, like blood tests.
- **Pediatric care:** For babies and children. Includes well-child visits and shots. Dental and eye care for those under age 19.

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Checklist to Apply for Health Insurance



Looking to apply for individual or family insurance in Arkansas?
Planning on signing up on the Marketplace?

Use this checklist to help you enroll during Open Enrollment from November 1 to December 15.

What You Will Need to Apply

- Information on how you file your taxes (single, married, head of household)
- Household income you expect the following year
- Information for all persons you want on your plan:
 - Home and/or mailing address
 - Social security number(s)
 - Work and income info (such as pay stub, W-2 form, or wage and tax statement)
 - For any current health insurance: the carrier and policy number
- Legal immigrants also need document information.

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Important Dates for Buying Individual and Family Health Insurance in Arkansas



Arkansans can get a quality individual or family health insurance plan that covers costs for doctor visits, prescriptions and more. See plans at myARinsurance.com.

Key dates for buying insurance through the Marketplace:

November 1, 2018: Open Enrollment starts. This is the first day you can enroll, re-enroll or change your plan for 2019. This allows your new plan to start January 1, 2019.

December 15, 2018: Last day to enroll or change a plan to start on January 1, 2019. After this date you can only enroll or change a plan if you have a life-changing event, like divorce, moving or having a baby. Such events qualify you for a Special Enrollment Period.

January 1, 2019: Coverage begins for those who register or change plans before December 15, 2018.

Get peace of mind for you and your family.

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Do You Want to Change or Update Your Health Plan for 2019?



You must Act from November 1 to December 15, 2018

Did you buy health insurance for 2018 through the Marketplace? If so, you can keep, change, or update your plan for 2019.

To start your new plan January 1, 2019, you must make changes by December 15, 2018.

Look for Two Important Letters in the Mail by November 1

The letters are from your insurance company and the Marketplace.

They will tell you:

- What plan you will have if you don't change it by December 15
- Any change in help with your monthly cost (premium)

If you don't act by December 15, you will be

- Renewed in your current plan, or
- Enrolled in a plan that is similar to your current plan

Important Facts about Changing Your Plan

- **Make sure you get the help you deserve to lower the cost.** If you don't update your income or household info, your premium tax credit and other savings could be wrong for 2018.
- **New plans for 2019 may be better than your current one.** See if a new plan is a better fit for your needs.
- **In some cases, you won't be automatically re-enrolled.** It's best to log in to make sure you're covered starting January 1, 2019.

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Mental Health Coverage

Plans through My Arkansas Insurance have Comprehensive Benefits



Your mental health plays a key role in your overall wellbeing. Enrolling for health coverage through My Arkansas Insurance ensures you'll have access to crucial mental health care, such as:

- Behavioral health treatment, such as psychotherapy and counseling
- Mental and behavioral health inpatient services
- Substance use disorder (commonly known as substance abuse) treatment

Pre-existing mental and behavioral health conditions are covered and spending limits aren't allowed.

- You can't be denied coverage or be charged more just because you have any pre-existing condition, including mental health and substance use disorder conditions
- Coverage for treatment of all pre-existing conditions begins the day your coverage starts
- Your health coverage plan cannot put yearly or lifetime dollar limits on coverage of any essential health benefit, including mental health and substance use disorder services

All plans must provide certain equal protections between mental health and substance abuse benefits on the one hand, and medical and surgical benefits on the other.

Generally speaking, this means limits applied to mental health and substance abuse services can't be more restrictive than limits applied to medical and surgical services. Limits covered by these protections include:

- **Financial** – like deductibles, copayments, coinsurance, and out-of-pocket limits
- **Treatment** – like limits to the number of days or visits covered
- **Care management** – like being required to get authorization of treatment before receiving it

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Preventive Health Care for Women



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Health insurance plans available from My Arkansas Insurance offer free preventive coverage for a comprehensive set of benefits. Specific benefits for women include:

1. **Breast cancer genetic test counseling (BRCA)** for women at higher risk
2. **Breast cancer mammography screenings** every one to two years for women over 40
3. **Breast cancer chemoprevention counseling** for women at higher risk
4. **Cervical cancer screening** for sexually active women
5. **Chlamydia infection screening** for younger women and other women at higher risk
6. **Domestic and interpersonal violence screening and counseling** for all women
7. **Gonorrhea screening** for all women at higher risk
8. **HIV screening and counseling** for sexually active women
9. **Human Papillomavirus (HPV) DNA test** every three years for women with normal cytology results who are 30 or older
10. **Osteoporosis screening** for women over age 60 depending on risk factors
11. **Rh incompatibility screening** follow-up testing for women at higher risk
12. **Sexually transmitted infections counseling** for sexually active women
13. **Syphilis screening** for women at increased risk
14. **Tobacco use screening and interventions**
15. **Well-woman visits** to get recommended services for women under 65

Another key component of women's reproductive health is access to contraception. The following FDA-approved contraceptive methods prescribed by a woman's doctor are covered under plans for free.

1. **Barrier methods** like diaphragms and sponges
2. **Hormonal methods** like birth control pills and vaginal rings
3. **Implanted devices** like intrauterine devices (IUDs)
4. **Emergency contraception**
5. **Sterilization procedures**
6. **Patient education and counseling**

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Health Benefits for Pregnant Women



For pregnant women or those hoping to become pregnant, health coverage is a vital part of having a healthy baby. When you enroll for health insurance through My Arkansas Insurance, prenatal care will be provided to ensure a healthy pregnancy and a healthier baby.

Along with regular prenatal visits and labor and delivery, below is a list of screenings and tests covered in your health insurance plan to keep you and your baby healthy during pregnancy.

- 1. Anemia screening** on a routine basis
- 2. Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women. This includes a free breast pump.
- 3. Folic acid supplements** for women who may become pregnant to help your baby's development
- 4. Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- 5. Screening for diseases that could hurt your baby,** like gonorrhea or syphilis for all women at higher risk
- 6. Hepatitis B screening** for pregnant women at their first prenatal visit
- 7. Rh incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
- 8. Expanded help to stop smoking** for pregnant tobacco users
- 9. Urinary tract or other infection screenings**

And, after you have your baby, you can talk to your doctor about contraception options, like birth control pills, that are covered by your health insurance.

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Understanding Special Enrollment Periods



If you have a major life event that affects your family size, location, income, or other big changes – you may qualify to get health coverage outside of Open Enrollment. This is called a Special Enrollment Period.

Who Qualifies for Special Enrollment Periods?

The Marketplace recognizes big changes, called “Qualifying Life Events,” as reasons for individuals to be able to get coverage outside of Open Enrollment. Qualifying Life Events include:

Loss of Health Insurance:

- Losing COBRA coverage
- Losing eligibility for Arkansas Works or Medicare
- Losing coverage through a family member
- Losing coverage through a job, including if your spouse has lost coverage

Changes in Household Size:

- Getting married
- Having a baby, adopting a child or placing a child for adoption or in foster care
- Getting divorced or legally separated

Changes in Residence:

- Moving outside of your insurer’s coverage area
- Gaining citizenship
- Leaving incarceration

Other Reasons:

- Gaining status as a member of a federally recognized tribe
- Turning 26 and aging off your parents’ plan
- AmeriCorps members starting or ending their service

How Long Do I Have to Apply?

Generally, you have 60 days after the date of the qualifying event to apply for a Special Enrollment Period.

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Agent/Broker Referral Program: My Arkansas HelpLine



Health Insurance the Arkansas Way.

my Arkansas HelpLine 
1 (844) 355-3262

What is My Arkansas HelpLine?

My Arkansas HelpLine is a new referral program, operated by the Arkansas Health Insurance Marketplace (AHIM) working in conjunction with Arkansas Foundation for Medical Care (AFMC). It is staffed by AFMC professionals who assist callers in finding a locally-registered, state-licensed participating agent/broker in their home county to provide direct assistance with Marketplace enrollment and health insurance plan selection. Personalized assistance is provided over the telephone or in-person by local insurance professionals.

What are the Benefits to Agents/Brokers of Participating in My Arkansas HelpLine?

- **Local Referrals:** Supported by an in-state call center, staffed and operated by AFMC, consumers will be connected directly to participating, licensed agents/brokers who live and work in their county.
- **No Additional Fees or Trainings:** Consumer referrals are provided to you at no cost and with no additional training requirement. It is simply an additional benefit provided to agent/broker partners through Arkansas Health Insurance Marketplace.
- **Reimbursement for Program-Sponsored Community Events:** Approved outreach opportunities can be financially supported by AHIM in an effort to help fund agent/broker support by reimbursing you for the time you devote to securing new leads (self-referrals) and assisting consumers referred to you through the program.

How Do I Register to Participate in the Program?

Licensed, in-state agents/brokers can register to receive **My Arkansas HelpLine** referrals and attend program-sponsored community events by completing the agent/broker referral program application, which can be accessed by clicking [here](#). You will be asked to provide the information necessary to become a program participant and to agree to the program's terms of participation.

How Does The Program Work?

- Consumers request assistance by calling 1 (844) 355-3262, Monday - Friday, 8:00 a.m. to 4:30 p.m., where they will speak with an AFMC professional who will direct the consumer's inquiry to a participating agent/broker in their area.
- Information provided in the agent/broker registration will assist AFMC staff in identifying the most appropriate agent/broker best equipped to assist with that particular situation.
- Preference will be given to an agent/broker who speaks the consumer's language and is licensed to provide support in the consumer's home county.
- If more than one agent/broker meets these criteria, a round-robin approach will direct the referral to the next participating agent/broker.
- Once the referral is made, a record of that referral will be added to the program database and the agent/broker will be able to document the outcome of the referral application, eligibility, enrollment or non-productive.

*AHIM has allocated a pool of moneys for the sole purpose of reimbursing agent/brokers participating in the referral program for identifying and attending local events, where they will establish new self-referrals and report on outcomes. All A/B Referral Program participants are automatically eligible for receiving reimbursement for attending community-based events for the purpose of initiating self-referrals; however, all identified events will be submitted through a registration and approval process. Outreach Events through the referral program will be regulated and administered by AFMC, based on criteria and priorities set forth by AHIM. Event requests will be reviewed and approved on a first-come, first-served basis.

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