Healthy Arkansas Dual Advantage (PPO D-SNP)

Summary of Benefits

January 1, 2027 – December 31, 2027

To be a member of our plan, you must be entitled to Medicare Part A, have Medicare Part B, reside in our service area, and receive certain levels of assistance from the Arkansas Department of Human Services, Division of Medical Services (DMS). This plan may enroll members who qualify under the following Medicaid categories: FBDE, QMB+, QMB, SLMB+, SLMB, QI, and QDWI. The Service area for Healthy Arkansas Dual Advantage (PPO D-SNP) includes the following counties: Baxter, Benton, Boone, Carroll, Cleburne, Craighead, Crawford, Faulkner, Fulton, Garland, Grant, Hot Spring, Howard, Independence, Izard, Jefferson, Lawrence, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Newton, Poinsett, Pulaski, Saint Francis, Saline, Searcy, Sebastian, Sharp, Stone, Union, Washington, and White.

We're here to help

You may have questions as you read through this document, and that's OK. We are here to help. Please call us at 844-325-0275 (TTY users dial 711), 8:00 am – 8:00 pm CST 7 days a week from October 1 to March 31, and Monday through Friday from April 1 to September 30.

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

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Comparing Coverage
If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or you can use the Medicare Plan Finder on www.medicare.gov.

More about Original Medicare
If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare handbook.

View the handbook online at:
www.medicare.gov/medicare-and-you

Get a copy of the handbook by calling:
1-800-MEDICARE (1-800-633-4227),
24 hours a day, 7 days a week. TTY users should call 1-877-486-2048

About the Plan

Which doctors, hospitals, and pharmacies can I use?
The Healthy Arkansas Dual Advantage (PPO D-SNP) Plan has a network of doctors, hospitals, and other providers. As a PPO plan, you can use providers who are in our network (in-network) or providers who are not in our network (out-of-network). For all Medicare-covered services, you have out-of-network coverage, usually at a higher cost share. Please refer to your *Evidence of Coverage* (EOC) for more detailed information.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

What do we cover?

- We cover all benefits covered by Original Medicare
- We also cover some benefits that Original Medicare does not cover. Some of these benefits are highlighted in this Summary of Benefits. For a complete list, please refer to your EOC.
- You can see the plan's Drug List, which is also called a formulary, which lists the Part D prescription drugs we cover, along with any restrictions on our website at www.healthy-ar.com
- You can also call us for a copy of the Drug List.

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

This benefit information is a brief summary of your benefits. It does not list every benefit, or every exclusion. To get a complete list, please refer to the EOC on our website at www.healthy-ar.com. You may also call us and ask us to mail you a copy of the EOC.

Your eligibility to enroll in this plan depends on your type of Medicaid. You can enroll in this plan if you are in one of these Medicaid categories:

Full Benefit Dual Eligible (FBDE): You qualify for Medicaid benefits but do not meet the income or resource criteria for QMB or SLMB. DMS may pay your Medicare cost sharing depending on your eligibility level.

Qualified Medicare Beneficiary Plus (QMB+): You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid helps pay your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare-covered services.

Qualified Medicare Beneficiary (QMB): You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid helps pay your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare-covered services.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Medicaid helps pay your Part B premium and provides full Medicaid benefits.

Specified Low-Income Medicare Beneficiary (SLMB): Medicaid helps pay your Part B premium.

Qualifying Individual (QI): Medicaid helps pay your Part B premium.

Qualified Disabled and Working Individual (QDWI): Medicaid helps pay your Part A premium.

Benefits - Medical		
	In-network	Out-of-network
Monthly Plan premium	$0 per month You must continue to pay your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by DMS.	

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Medical deductible	$0 or $900 annual deductible*, depending on your level of Medicaid eligibility. **The deductible applies only to certain Medicare covered services.*	
Maximum Out-of-pocket responsibility (MOOP)	$9,250. This is the most you will pay for in-network Medicare covered services[1] Combined in-network and out-of-network: $9,250[1] If you are eligible for Medicare cost-sharing assistance under DMS, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. *[1]The MOOP does not apply to non-Medicare covered services.*	
Inpatient hospital – Acute‡	$0 or $1,800 copayment per admission or stay	$0 or $1,800 copayment per admission or stay
Inpatient hospital – Mental health‡	$0 or $1,800 copayment per admission or stay	$0 or $1,800 copayment per admission or stay
Outpatient observation‡	0% or 20% coinsurance	0% or 40% coinsurance
Outpatient hospital (surgery)‡	0% or 20% coinsurance	0% or 40% coinsurance
Ambulatory surgical center (ASC)‡	0% or 20% coinsurance	0% or 40% coinsurance
Primary care (PCP)	0% or 20% coinsurance	0% or 30% coinsurance
Specialist visit	0% or 20% coinsurance	0% or 30% coinsurance
Preventive care (annual wellness visit, breast cancer screening, certain vaccines)	$0 copayment for all Medicare-covered preventive services	

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Emergency care	$0 or $115 copayment per visit. Copay is waived if admitted within 24 hours	
Urgently needed services	$0 or $40 copayment per visit	$0 or $40 copayment per visit
Diagnostic services:‡ Diagnostic tests and procedures‡ Lab services‡ Diagnostic radiology (CT, MRI)‡ Therapeutic radiology (radiation)‡ X-ray services‡	0% or 20% coinsurance	0% or 40% coinsurance

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Hearing services: Medicare covered hearing services Non-Medicare covered hearing services: Routine hearing exam Hearing aid fitting/evaluation Prescription hearing aids	**Medicare covered hearing services**: 0% or 20% coinsurance **Non-Medicare covered hearing services:** Routine hearing exams: $0 copayment for one exam per year Hearing aid fitting/evaluation: $0 copayment for one fitting/evaluation per year Hearing aids: Tier 1: $399 copayment per ear, limited to two aids per year Tier 2: $699 copayment per ear, limited to two aids per year	**Medicare covered hearing services**: 0% or 30% coinsurance **Non-Medicare covered hearing services:** 40% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs.

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Dental services: Medicare covered dental services Non-Medicare covered dental services: Routine dental visits Preventive services: Services include routine exams, x-rays, cleanings and fluoride treatment. Comprehensive services: Services include restorative services, Endodontics, Periodontics, Prosthodontics: removable and fixed, Maxillofacial Prosthetics, Oral and Maxillofacial Surgery, and Adjunctive General Services. Please note Implants and Orthodontics are not covered.	**Medicare covered Dental services**: 0% or 20% coinsurance **Non-Medicare covered dental services:** $3,000 combined annual allowance for diagnostic, preventive, and comprehensive dental care. This allowance is combined for in-network and out-of-network services. $0 copayment for covered preventive dental services including: routine exams, x-rays, cleanings, and fluoride treatment until the annual maximum is met. Two visits per year for routine exams and cleanings, one visit per year for x-rays and fluoride treatment. $0 copayment for covered comprehensive dental services until the annual maximum is met. Once the annual maximum is reached, you are responsible for all costs	**Medicare covered Dental services**: 0% or 30% coinsurance **Non-Medicare covered dental services:** $3,000 combined annual allowance for diagnostic, preventive, and comprehensive dental care. This allowance is combined for in-network and out-of-network services. 40% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Vision services: Medicare covered vision services Non-Medicare covered vision services	**Medicare covered diabetic retinal exam:** 0% or 20% coinsurance **Medicare covered glaucoma screening:** 0% or 20% coinsurance **Medicare covered eye exam:** 0% or 20% coinsurance **Medicare covered eyewear:** 0% or 20% coinsurance for Medicare covered standard frames and lenses after cataract surgery **Non-Medicare covered vision services:** Routine Vision: $0 copayment for one routine eye exam per year $300 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one pair every other year; all other categories are unlimited. Once the annual maximum is reached, you are responsible for all costs This allowance is combined for in-network and out-of-network services.	**Medicare covered diabetic retinal exam:** 0% or 30% coinsurance **Medicare covered glaucoma screening:** 0% or 20% coinsurance **Medicare covered eye exam:** 0% or 30% coinsurance **Medicare covered eyewear:** 0% or 30% coinsurance for Medicare covered standard frames and lenses after cataract surgery **Non-Medicare covered vision services:** 40% coinsurance $300 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one pair every other year; all other categories are unlimited. This allowance is combined for in-network and out-of-network services. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Outpatient mental health	**Psychiatrist and Mental health specialty outpatient services[2]:** 0% or 20% coinsurance [2] *Includes individual and group therapy sessions*	**Psychiatrist and Mental health specialty outpatient services[2]:** 0% or 30% coinsurance [2] *Includes individual and group therapy sessions*
Skilled nursing facility (SNF)[‡]	$0 copayment per day, days 1-20; $0 or $218 copayment per day, days 21-100	$0 copayment per day, days 1-20; $0 or $218 copayment per day, days 21-100
Diabetic supplies and services[‡] Diabetic therapeutic shoes and inserts[‡] Diabetic monitors[‡]: (Continuous Glucose Monitors (CGMs) and Blood Glucose Monitors (BGMs))	**Diabetic supplies and services[‡]:** $0 copayment **Diabetic therapeutic shoes and inserts[‡]:** 0% or 20% coinsurance **Diabetic monitors[‡]: (CGMs and BGMs):** 0% or 20% coinsurance	**Diabetic supplies and services[‡]:** 0% or 20% coinsurance **Diabetic therapeutic shoes and inserts[‡]:** 0% or 20% coinsurance **Diabetic monitors[‡]: (CGMs and BGMs):** 0% or 20% coinsurance
Ambulance services – Ground (non-emergent)[‡]	0% or 20% coinsurance	0% or 20% coinsurance
Ambulance services – Air[‡]	0% or 20% coinsurance	0% or 20% coinsurance
Transportation	$0 per trip Up to 60 one-way trips per year Members can travel up to 75 miles each one-way trip Trip allowance is combined for in-network and out-of-network	40% coinsurance You can submit for reimbursement, less any applicable coinsurance, up 60 one-way trips. Trip allowance is combined for in-network and out-of-network

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Medicare Part B drugs‡	**Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) ‡:** 0% to 20% coinsurance **Part B insulin‡:** 0% to 20% coinsurance, up to a $35 maximum per one-month supply	**Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) ‡:** 0% to 20% coinsurance **Part B insulin‡:** 0% to 20% coinsurance, up to a $35 maximum per one-month supply
Outpatient rehabilitation including physical therapy, occupational therapy, and speech language therapy (PT, OT, ST)‡	**Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) ‡:** 0% or 20% coinsurance	**Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) ‡:** 0% or 30% coinsurance

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Over-the-counter (OTC)	$340 monthly allowance All members receive this allowance for over-the-counter (OTC) items. It is a shared allowance with SSBCI* (Special Supplemental Benefits for the Chronically Ill); members who qualify for SSBCI may also use the same allowance for eligible SSBCI benefits. Please see the SSBCI row in this chart for more details. If a member qualifies, this allowance may be used for both benefits. Unused amounts roll over until the end of the plan year.	40% coinsurance (applies to OTC only; *SSBCI has no out-of-network coverage) You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.
In-home support services	$0 copayment 108 hours per year for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Hours are shared between in-network and out-of-network services.	$0 copayment 108 hours per year for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Hours are shared between in-network and out-of-network services. You can submit for reimbursement up to the hourly maximum.

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Benefits - Medical		
	In-network	Out-of-network
Fitness, Health Education, and Weight Management (combined package)	$150 combined annual allowance covering fitness, health education, and weight management together. Unused amounts do not roll over to the next year. This allowance is combined for in-network and out-of-network services.	40% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.
Bathroom safety devices	$200 annual allowance Unused amounts do not roll over to the next year. This allowance is combined for in-network and out-of-network services.	40% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Special Supplemental Benefits		
If you are diagnosed with one or more of the chronic conditions listed within our EOC and meet the eligibility criteria, you may be eligible for additional benefits under our plan. Enrollment in our plan does not guarantee eligibility.		
	In-network	Out-of-network
SSBCI – Special Supplemental Benefits for the Chronically Ill[†] The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. The top five eligible chronic conditions include: Cardiovascular Disease, Chronic Kidney Disease, Diabetes, Chronic lung disorders, and Overweight, Obesity, and Metabolic Disorder. There are other chronic conditions eligible for this benefit. Please see your EOC for detailed information. To be eligible, members must have one or more qualifying chronic conditions, be at high risk of hospitalization or other adverse health outcomes and require intensive care coordination.	$340 monthly allowance This is the same shared allowance described in the Over-the-counter (OTC) row. If you qualify, you may use this allowance for your SSBCI benefits, your OTC benefit, or both. SSBCI benefits include: Groceries (food and produce) General supports for living (utilities, rent, and mortgage assistance) Unused amounts roll over until the end of the plan year. **[†]Member must qualify to receive this benefit. Please refer to your *Evidence of Coverage* for more detailed information.**	Not covered

[‡]Services marked with a double dagger ([‡]), may require prior authorization and is the responsibility of your provider

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

Medicaid covered Benefits

This section provides information for members who have both Medicare and Medicaid, which is called “Dual Eligible”.

The benefits described in this Summary of Benefits previously are covered by Healthy Arkansas Dual Advantage (PPO D-SNP). Below is a list of Medicaid covered benefits. All Medicaid benefits are subject to DMS eligibility guidelines and requirements. If you have questions about your Medicaid eligibility, review your member handbook or contact DMS at 800-482-5431 (toll-free) or TTY 501-682-8933 or visit online at Humanservices.arkansas.gov/divisions-shared-services/medical-services/.

Medicaid may cover additional benefits that are not listed below. There may be limits for some services. If you need a service that is only covered by Medicaid, the provider you pick needs to be enrolled with Medicaid.

- Dental
    - General dentistry
    - Oral surgery
    - Orthodontia
- Durable Medical Equipment
    - Durable Medical Equipment (DME)
    - Medical supplies
    - Orthotics/Prosthetics
- Hospital Care
    - 23 hour observation
    - Emergency room services
    - Inpatient care
    - Organ Transplants
    - Outpatient care
- Mental Health
    - Inpatient psychiatric care
    - Outpatient hospital mental health service
    - Psychiatric residential treatment facilities
    - Therapeutic and evaluative mental health services

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

- Places of Service
    - Ambulatory Surgical Center (ASC)‡
    - Community homes for individuals with intellectual disabilities
    - Emergency room
    - Federally Qualified Health Center (FQHC)
    - Hospital inpatient and outpatient
    - Indian health
    - Intermediate care facilities for individuals with intellectual disabilities
    - Arkansas Department of Health
    - Nursing facilities
    - Office visits – Physician/Physician Assistant/Nurse Practitioner/Registered Nurse
    - Rural Health Clinics (RHC)
    - Swing bed
- Professional Medical Services
    - Chiropractic
    - Dialysis
    - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (EPSDT)
    - Laboratory
    - Occupational therapy
    - Physical therapy
    - Physician administered drugs and devices
    - Physician/Nurse Practitioner/Registered Nurse office visits
    - Podiatry
    - Private duty nursing
    - Radiology and advanced imaging
    - Speech therapy
- Transportation
    - Air transportation
    - Emergency Transportation
    - Non-Emergency Medical Transportation (NET)
- Wellness
    - Adult wellness screenings
    - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) wellness screenings

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    - Lead screening
    - Vaccines for children
- Other Services
    - Family planning
    - Hearing services and hearing aids
    - Home health
    - Hospice
    - Long term care services
    - Prescription drugs
    - School based administrative claims program
    - School health related services program
    - Vaccines and vaccines for children program
    - Vision and eyeglasses

Cost shares may differ based on your Medicaid eligibility level. Members with full Medicaid benefits or Medicaid cost-sharing assistance may pay $0. Members with partial Medicaid benefits may pay the Medicare cost-sharing amount listed. Medicaid coverage of cost-sharing is determined by your Medicaid eligibility status.

<table>
<tr><th colspan="2">Prescription drug benefits</th></tr>
<tr><td>Deductible</td><td>If you receive Extra Help, you have a $0 deductible. If you do not receive Extra Help, you have a $700 deductible for Tier 3, Tier 4, and Tier 5 drugs.</td></tr>
<tr><td>Initial coverage</td><td>In this stage, you pay the following until your yearly out-of-pocket costs reach $2,400.
You won’t pay more than 25% coinsurance or $35, whichever is less, for a one-month (30-day) supply of insulin. You won’t pay more than 25% coinsurance or $105, whichever is less, for a 100-day supply of insulin.
<table>
<tr><th>Tier</th><th>30 day supply</th><th>100 day supply</th></tr>
<tr><td>Tier 1 - Preferred Generic</td><td>$0 copayment</td><td>$0 copayment</td></tr>
<tr><td>Tier 2 - Generic</td><td>$0 copayment</td><td>$0 copayment</td></tr>
<tr><td>Tier 3 - Preferred Brand</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4 - Non-preferred Drug</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 - Specialty</td><td>25% coinsurance</td><td>Tier 5 is only covered up to a 30-day supply</td></tr>
</table></td></tr>
<tr><td>Catastrophic coverage</td><td>After your yearly out-of-pocket costs reach $2,400, the plan pays the full costs of your Part D drugs, and you pay nothing.</td></tr>
</table>

If you receive Extra Help, your copays are lower. Depending on your level of Extra Help, you pay: Generic drugs (including brand drugs treated as generic): $0, $1.65, or $5.80 per prescription. All other covered drugs: $0, $5.00, or $14.40 per prescription.

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Healthy Arkansas Dual Advantage (PPO D-SNP) is a Medicare Advantage PPO with a Medicare Contract. Our DSNPs have contracts with State Medicaid Programs. Enrollment in our plans depends on contract renewal. Our plans are not available in all counties.

Benefits, features, and/or devices vary by plan/service area. Limitations, exclusions, and restrictions may apply. Contact the plan for more information.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

This information is not a complete description of benefits. Please see the EOC for a complete description of benefits, exclusions, limitations, and conditions of coverage.

The formulary, pharmacy network, and/or provider network can change at any time. You will receive notice when necessary.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Healthy Arkansas, Inc.'s pharmacy network includes limited lower-cost, preferred pharmacies in our service area, including in suburban and rural counties across Arkansas. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 844-325-0275, and TTY 711 or consult the online pharmacy directory at www.healthy-ar.com.

Out-of-network/non-contracted providers are under no obligation to treat Healthy Arkansas, Inc. members, except in emergency situations. Please call our Member Services number or see your EOC for more information.

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