

Arkansas 2014 Silver Plan Cost Sharing Comparison Chart- All Regions

Company	Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas							Ambetter of Arkansas							Blue Cross Blue Shield, A Multi-State Plan				
Service Area:	All		All		C	NE	NW	SC	WC	C	NW	C, NW, WC		C, NW, WC		C, NW, WC		C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003		AR0080004		AR0090003		AR0090004		AR0100003	AR0100004	AR0350001	
Marketing Name:	Silver 2500	Silver 3500	Silver Basic Plus Statewide Network	Silver Basic Plus	Silver Basic Plus Statewide Network	Silver Basic Plus	Silver Basic Plus	Silver Basic Plus Central Arkansas High Value Network	Silver Basic Plus Northwest Arkansas High Value Network	Ambetter Silver 1	Ambetter Silver 2	Ambetter Silver 1 + Vision	Ambetter Silver 2 + Vision	Ambetter Silver 1 + Vision + Adult Dental	Ambetter Silver 2 + Vision + Adult Dental	Blue Cross Blue Shield 2000, a Multi-State Plan					
Deductible (In-Network): <small>Deductible is combined medical and drug unless otherwise indicated.</small>	\$2,500	\$3,500	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$2,000 (medical) / \$500 (drug)	\$3,000 (medical) / \$1,000 (drug)	\$2,000 (medical) / \$500 (drug)	\$3,000 (medical) / \$1,000 (drug)	\$2,000 (medical) / \$500 (drug)	\$3,000 (medical) / \$1,000 (drug)	\$2,000				
MOOP (In-Network):	\$6,300	\$6,000	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,350	\$6,300				
Coinsurance (In-Network):	20%	20%	0%	0%	0%	0%	0%	0%	0%	0%	30%	20%	30%	20%	30%	20%	15%				
Office Visits and Outpatient Services																					
Primary Care Visit to Treat an Injury or Illness	In Network	\$25 Copay	\$25 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$30 Copay		
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible		

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Service Area:		All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Preventive Care/Screening/Immunization	In Network	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$30 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Specialist Visit	In Network	\$60 Copay	\$50 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	In Network	30% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	25% Coinsurance after deductible
	Out of Network	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible

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Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Chiropractic Care	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$30 Copay
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Acupuncture	In Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Nutritional Counseling	In Network	Not Covered	Not Covered	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Well Child Care	In Network	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered

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Pharmacy																	
Generic Drugs	In Network	\$15 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$10 Copay	\$20 Copay	\$10 Copay	\$20 Copay	\$10 Copay	\$15 Copay
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preferred Brand Drugs	In Network	\$55 Copay	\$50 Copay	\$70 Copay	\$70 Copay	\$70 Copay	\$70 Copay	\$70 Copay	\$70 Copay	\$70 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$55 Copay
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Non-Preferred Brand Drugs	In Network	\$90 Copay	\$90 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay after deductible	\$100 Copay after deductible	\$90 Copay
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Specialty Drugs	In Network	\$200 Copay	\$200 Copay	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$300 Copay
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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Off Label Prescription Drugs	In Network	Not Covered	Not Covered	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	15% Coinsurance after deductible
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	Varies according to tier	Not Covered
Testing and Imaging																	
X-rays and Diagnostic Imaging	In Network	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	No Charge
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Imaging (CT/PET Scans, MRIs)	In Network	\$150 Copay	\$150 Copay	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$200 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Laboratory Outpatient and Professional Services	In Network	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	No Charge
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance

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Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Allergy Testing	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$30 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible
Inpatient Services																	
Inpatient Hospital Services (e.g., Hospital Stay)	In Network	\$200 Copay per Day	\$250 Copay per Day	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1200 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$1000 Copay per Day after deductible	\$250 Copay per Day
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Emergency and Urgent Care																	
Emergency Room Services	In Network	\$150 Copay	\$175 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay
	Out of Network	\$150 Copay	\$175 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay after deductible	\$250 Copay
Emergency Transportation/Ambulance	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible

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Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001	
Urgent Care Centers or Facilities	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$350 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	15% Coinsurance after deductible	
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible	
Durable Medical Equipment																		
Durable Medical Equipment	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible
Prosthetic Devices	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible
Mental and Behavioral Health and Substance Abuse																		
Mental/Behavioral Health Outpatient Services	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	35% Coinsurance after deductible

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Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Mental/Behavioral Health Inpatient Services	In Network	\$200 Copay per day	\$250 Copay per day	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$250 Copay per day
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Substance Abuse Disorder Inpatient Services	In Network	\$200 Copay	\$250 Copay	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$1,000 Copay per day after deductible	\$250 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Substance Abuse Disorder Outpatient Services	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$30 Copay
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Mental Health Other	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:	All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All	
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001	
Rehabilitation and Habilitation																	
Rehabilitative Occupational and Rehabilitative Physical Therapy	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered
Rehabilitative Speech Therapy	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered
Outpatient Rehabilitation Services	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered
Habilitation Services	In Network	\$25 Copay	\$25 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$30 Copay
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:	All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All	
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001	
Surgery																	
Inpatient Physician and Surgical Services	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	In Network	30% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	25% Coinsurance after deductible
	Out of Network	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	45% Coinsurance after deductible
Reconstructive Surgery	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered
Gastric Electrical Stimulation	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company	Arkansas Blue Cross and Blue Shield			QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan
Service Area:	All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001

Treatments and Therapies

Chemotherapy	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Radiation	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Infertility Treatment	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Infusion Therapy	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company	Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas							Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan
Service Area:	All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001

Vision

Routine Eye Exam for Children	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	35% Coinsurance after deductible
Routine Eye Exam (Adult)	In Network	No Charge	No Charge	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	Not Covered	Not Covered	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	No Charge
	Out of Network	Not Covered	Not Covered	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	Not Covered	Not Covered	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	Not Covered
Adult Frames or Lenses	In Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	Not Covered
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	Not Covered
Eye Glasses for Children	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	\$20 Copay	35% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company	Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas							Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan
Service Area:	All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:	AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001

Dental

Routine Dental Services (Adult)	In Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	No Charge	No Charge	Not Covered
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Basic Dental Care - Adult	In Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance	50% Coinsurance	Not Covered
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Accidental Dental	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible	
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible
Dental Anesthesia	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible	
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:		All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Women's Services																	
Delivery and All Inpatient Services for Maternity Care	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1000 Copay per day after deductible	\$1000 Copay per day after deductible	\$1000 Copay per day after deductible	\$1000 Copay per day after deductible	\$1000 Copay per day after deductible	\$1000 Copay per day after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Prenatal and Postnatal Care	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	\$40 Copay	\$50 Copay	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Other																	
Diabetes Education	In Network	No Charge	No Charge	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	No Charge
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance
Diabetes Care Management	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	\$60 Copay	\$75 Copay	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:		All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Skilled Nursing Facility	In Network	\$200 Copay per Day	\$250 Copay per Day	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$300 Copay per Day after deductible	\$100 Copay per Day after deductible	\$100 Copay per Day after deductible	\$100 Copay per Day after deductible	\$100 Copay per Day after deductible	\$100 Copay per Day after deductible	\$100 Copay per Day after deductible	\$250 Copay per Day
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Home Health Care Services	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Private-Duty Nursing	In Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Out of Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hospice Services	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:		All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Dialysis	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible
Transplant	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1,200 Copay per day after deductible	\$1000 Copay after deductible	\$1000 Copay after deductible	\$1000 Copay after deductible	\$1000 Copay after deductible	\$1000 Copay after deductible	\$1000 Copay after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible
Hearing Aids	In Network	No Charge	No Charge	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	No Charge
	Out of Network	No Charge	No Charge	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance	No Charge
Cochlear Implants	In Network	20% after deductible	20% after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% after Deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% after deductible

Silver Plan Cost Sharing Comparison - All Regions

Company		Arkansas Blue Cross and Blue Shield		QualChoice Health Insurance of Arkansas						Ambetter of Arkansas						Blue Cross Blue Shield, A Multi-State Plan	
Service Area:		All	All	C	NE	NW	SC	WC	C	NW	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	C, NW, WC	All
Plan Number:		AR0270001	AR0280001	AR0070003	AR0070009	AR0070015	AR0070021	AR0070027	AR0070033	AR0070039	AR0080003	AR0080004	AR0090003	AR0090004	AR0100003	AR0100004	AR0350001
Treatment for Temporomandibular Joint Disorders	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	30% Coinsurance	20% Coinsurance	30% Coinsurance	20% Coinsurance	30% Coinsurance	20% Coinsurance	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	35% Coinsurance after deductible
Inherited Metabolic Disorder PKU	In Network	20% Coinsurance after deductible	20% Coinsurance after deductible	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	15% Coinsurance after deductible
	Out of Network	40% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	35% Coinsurance after deductible
Notes	BCBS Notes: Nutritional Counseling is covered under diabetes care management.			QCA Notes: Nutritional Counseling is covered under diabetes care management.						Ambetter Notes: Nutritional Counseling and foot care for diabetics is covered under Diabetes Care Management cost sharing. Nutritional counseling is covered for pregnant women							