Arkansas
**BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

# Small Group Platinum 500 Elite PPO
# Schedule of Benefits

This Schedule of Benefits is part of the Benefit Certificate, Form 17-321 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

| | |
|---|---|
| **Lifetime Maximum –** per Covered Person (all services) | No Lifetime Maximum |
| **Dependent Age** | 26 |

| | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Deductible -** Individual | $500.00 | $1,000.00 |
| **Deductible –** Family | $1,000.00 | $2,000.00 |
| **Annual Limitation on Cost Sharing -** Individual | $1,500.00 | $6,000.00 |
| **Annual Limitation on Cost Sharing -** Family | $3,000.00 | $12,000.00 |

| **COVERED BENEFITS AND SERVICES** | **In-Network Copayment** | **In-Network Coinsurance** | **Out-of-Network Coinsurance** |
|---|---|---|---|
| **Professional Services** | | | |
| Primary Care Physician (PCP) Visits | $20 | 0% | 30% after Ded |
| Specialist Office Visit (consultation/evaluation only) | $40 | 0% | 30% after Ded |
| Services and procedures provided in the Specialist office other than consultation and evaluation | | 10% after Ded | 30% after Ded |
| **Preventive Health Services** | | | |
| Immunizations (by PCP) | $0 | 0% | Not Covered |
| Well Baby Care – through 12 months of age (by PCP) | $0 | 0% | Not Covered |
| Well Child Exam – over 12 months of age (by PCP) | $0 | 0% | Not Covered |
| Physical Exams – Adults (by PCP) | $0 | 0% | Not Covered |
| Routine Gynecological visit (PCP or GYN) | $0 | 0% | Not Covered |
| Mammogram and Pap Smear, PSA | $0 | 0% | Not Covered |
| Routine Vision Exam – Adult (one per visit per Adult Covered Person every 2 years) | $0 | 0% | Not Covered |
| Bone Density | $0 | 0% | Not Covered |
| **Allergy Services** | | | |
| Services provided by the PCP | $20 | | 30% after Ded |
| Services provided by the Specialist | $40 | 10% after Ded | 30% after Ded |
| **Hospital Services (Prior Approval Required)** | | | |
| Inpatient Services - Semi-private room | | 10% after Ded | 30% after Ded |
| Outpatient Hospital Services | | 10% after Ded | 30% after Ded |
| Outpatient Surgical Services | | 10% after Ded | 30% after Ded |
| **Emergency Care Services** | | | |
| Urgent Care Center | $40 | 10% after Ded | 30% after Ded |
| Emergency Room | | 10% after Ded | Same as in network |
| Observation Services | | 10% after Ded | Same as in network |
| **Ambulance Services** | | 10% after Ded | Same as in network |
| **Ambulatory Surgery Centers** (Prior Approval Required) | | 10% after Ded | 30% after Ded |
| **Outpatient Diagnostic Services** | | | |
| Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office) | | 10% after Ded | 30% after Ded |

| COVERED BENEFITS AND SERVICES (CONT) | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Advanced Diagnostic Imaging Services** CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology (Prior Approval Required) | | 10% after Ded | 30% after Ded |
| **Maternity and Family Planning Services* (Prior Notification Required)** | | | |
| Prenatal and Postnatal outpatient care (PCP Copay may apply to the first visit only) | | 10% after Ded | 30% after Ded |
| Inpatient Maternity Services | | 10% after Ded | 30% after Ded |
| Infertility Counseling and Infertility Testing | | 10% after Ded | Not Covered |
| Infertility Treatment – (Prior Approval Required) | | 10% after Ded | Not Covered |
| ***Out-of-Network Newborn coverage limited to $2,000 per Covered Person for all services (first 90 days after birth)*** | | | |
| **Rehabilitation Services** | | | |
| **Inpatient Rehabilitation Services** (Prior Approval Required) (Limited to 60 days per Covered Person per calendar year) | | 10% after Ded | Not Covered |
| **Outpatient Rehabilitation Services:** Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year) | $20 | 0% | Not Covered |
| **Chiropractic Services** (Limited to the Outpatient Rehabilitation Services aggregate visit limit specified above) | $40 | 10% after Ded | Not Covered |
| **Cardiac Rehabilitation** (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities. | | 10% after Ded | Not Covered |
| **Neurologic Rehabilitation Facility Services** (Prior Approval Required) – Limited to 60 days per lifetime. | | 10% after Ded | 30% after Ded |
| **Habilitation Services** | | | |
| **Developmental Services:** (Limited to a maximum of 180 units per Covered Person per calendar year) | | 10% after Ded | Not Covered |
| **Outpatient Habilitation Services:** Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year) | $20 | 0% | Not Covered |
| **Chiropractic Services** (Limited to the Outpatient Habilitation Services aggregate visit limit specified above) | $40 | 10% after Ded | Not Covered |
| **Mental Illness and Substance Use Disorder Services** | | | |
| **Inpatient Hospital Services** (Prior Approval Required) Semi-private room | | 10% after Ded | 30% after Ded |
| **Partial Hospitalization** | | 10% after Ded | 30% after Ded |
| **Residential Treatment Centers** (Prior Approval Required) Limited to 60 days per Covered Person per calendar year. | | 10% after Ded | 30% after Ded |
| **Outpatient** (consultation, evaluation, psychotherapy only) | $20, 3 visits free before copay* | 0% | 30% after Ded |
| **Outpatient** Other services and procedures provided in the office or outpatient facility | | 10% after Ded | 30% after Ded |

| COVERED BENEFITS AND SERVICES (CONT) | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Durable Medical Equipment (DME) and Medical Supplies** (Prior Approval for DME for which cost exceeds $5,000) | | 10% after Ded | 30% after Ded |
| **Prosthetic and Orthotic Devices and Services** (Prior Approval on any device for which cost exceeds $20,000) | | 10% after Ded | 30% after Ded |
| **Diabetes Management Services** | | | |
| Diabetic Supplies, shoes (per Medicare guidelines) | | 10% after Ded | 30% after Ded |
| Diabetic Self-Management Training (Allowance or Allowable Charge of $250) | | $0 | 30% after Ded |
| **Skilled Nursing Facility** (Prior Approval Required) (Limited to 60 Days per Covered Person per calendar year) | | 10% after Ded | 30% after Ded |
| **Home Health Services** (Prior Approval Required) (Limited to 50 visits per Covered Person per calendar year) | | 10% after Ded | 30% after Ded |
| **Hospice Care** (Prior Approval Required) | | 10% after Ded | 30% after Ded |
| **Dental Care Services** Damage to non-diseased teeth due to accident | | 10% after Ded | 30% after Ded |
| **Reconstructive Surgery (Prior Approval Required)** | | | |
| Correct defects due to Accident or Surgery. | | 10% after Ded | Not Covered |
| **Reduction Mammoplasty (Prior Approval Required)** | | 10% after Ded | Not Covered |
| **Pediatric Vision**- Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year) | | 10% after Ded | 30% after Ded |
| **Medications** | | | |
| Hospital or Ambulatory Surgical Center | | 10% after Ded | 30% after Ded |
| Physician's Office (PCP only) | $20 | 0% | 30% after Ded |
| Retail Pharmacy (Drug Store) | | | |
| Preventive Medications | $0 | 0% | Not Covered |
| Generic Medications | $10 | 0% | Not Covered |
| Preferred Brand Name Medications | $30 | 0% | Not Covered |
| Non-Preferred Brand Name Medications | $50 | 0% | Not Covered |
| Specialty Pharmacy (Prior Approval Required) | | | |
| Preferred Specialty Medications | $100 | 0% | Not Covered |
| Non-Preferred Specialty Medications | $200 | 0% | Not Covered |
| Home Infusion Therapy Pharmacy - Injectable Medications | | 10% after Ded | 30% after Ded |
| **Organ Transplant Services (Prior Approval Required**- except kidney and cornea transplants.**)** | | 10% after Ded | 30% after Ded |
| **Medical Disorder Requiring Specialized Nutrients and Formulas** (Prior Approval Required) | | 10% after Ded | 30% after Ded |
| **Hearing Aid Benefits -** $1,400 per Ear per Covered Person. | | 0% | 0% |
| **Temporomandibular Joint Benefits** (Prior Approval Required)A | | 10% after Ded | 30% after Ded |
| **Miscellaneous Health Interventions** | | 10% after Ded | 30% after Ded |

*"3 visits free before copay" applies to the first 3 claims of Outpatient Mental Health Services in the calendar year.

**NOTE:**

In-Network Services for which the Covered Person has a Coinsurance responsibility are subject to the In-Network Deductible, in most cases.

Out-of-Network Deductible and Coinsurance amounts do not apply to the In-Network Deductible or Annual Limitation on Cost Sharing.
Expenses incurred for services that exceed specific benefit limits are not applied to the Annual Limitation on Cost Sharing.

The Covered Person may be responsible for difference between billed charges and the Allowance or Allowable Charges for services covered at the Out-of-Network benefit level.

Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the service or equipment meets the Primary Coverage Criteria set out in your Benefit Certificate.

*All Covered Services are subject to the Arkansas Blue Cross and Blue Shield Allowance or Allowable Charge.*