



This Schedule of Benefits is part of the Benefit Certificate, Form 17-322 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

<b>Lifetime Maximum – per Covered Person (all services)</b>	No Lifetime Maximum		
<b>Dependent Age</b>	26		
	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Deductible - Individual</b>	\$4,000.00	\$6,000.00	
<b>Deductible – Family</b>	\$8,000.00	\$12,000.00	
<b>Annual Limitation on Cost Sharing - Individual</b>	\$6,000.00	\$9,000.00	
<b>Annual Limitation on Cost Sharing - Family</b>	\$12,000.00	\$18,000.00	
<b>COVERED BENEFITS AND SERVICES</b>	<b>In-Network Copayment</b>	<b>In-Network Coinsurance</b>	<b>Out-of-Network Coinsurance</b>
<b>Professional Services</b>			
Primary Care Physician (PCP) Visits	\$25	0%	40% after Ded
Specialist Office Visit (consultation/evaluation only)	\$50	0%	40% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation		20% after Ded	40% after Ded
<b>Preventive Health Services</b>			
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
Prostate Cancer Screening (for men age 40 or older)	\$0	0%	Not Covered
<b>Allergy Services</b>			
Services provided by the PCP	\$25		40% after Ded
Services provided by the Specialist	\$50	20% after Ded	40% after Ded
<b>Hospital Services</b>			
Inpatient Services - Semi-private room		20% after Ded	40% after Ded
Outpatient Hospital Services		20% after Ded	40% after Ded
Outpatient Surgical Services		20% after Ded	40% after Ded
<b>Emergency Care Services</b>			
Urgent Care Center	\$50	20% after Ded	40% after Ded
Emergency Room		20% after Ded	Same as in network
Observation Services		20% after Ded	Same as in network
<b>Ambulance Services</b>			
		20% after Ded	Same as in network
<b>Ambulatory Surgery Centers</b>			
	\$100	20% after Ded	40% after Ded
<b>Outpatient Diagnostic Services</b>			
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)		20% after Ded	40% after Ded

<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network Copayment</b>	<b>In-Network Coinsurance</b>	<b>Out-of-Network Coinsurance</b>
<b>Advanced Diagnostic Imaging Services</b> CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology		20% after Ded	40% after Ded
<b>Maternity and Family Planning Services* (Prior Notification Required)</b>			
Prenatal and Postnatal outpatient care (PCP Copay may apply to the first visit only)		20% after Ded	40% after Ded
Inpatient Maternity Services		20% after Ded	40% after Ded
Infertility Counseling and Infertility Testing		20% after Ded	Not Covered
Infertility Treatment		20% after Ded	Not Covered
<b>*Out-of-Network Newborn coverage limited to \$2,000 per Covered Person for all services (first 90 days after birth)</b>			
<b>Rehabilitation Services</b>			
<b>Inpatient Rehabilitation Services</b> (Limited to 60 days per Covered Person per calendar year)		20% after Ded	Not Covered
<b>Outpatient Rehabilitation Services:</b> Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year)	\$25	0%	Not Covered
<b>Chiropractic Services</b> (Limited to the Outpatient Rehabilitation Services aggregate visit limit specified above)	\$50	20% after Ded	Not Covered
<b>Cardiac Rehabilitation</b> (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities.		20% after Ded	Not Covered
<b>Neurologic Rehabilitation Facility Services</b> – Limited to 60 days per lifetime.		20% after Ded	40% after Ded
<b>Habilitation Services</b>			
<b>Developmental Services:</b> (Limited to a maximum of 180 units per Covered Person per calendar year)		20% after Ded	Not Covered
<b>Outpatient Habilitation Services:</b> Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year)	\$25	0%	Not Covered
<b>Chiropractic Services</b> (Limited to the Outpatient Habilitation Services aggregate visit limit specified above)	\$50	20% after Ded	Not Covered
<b>Mental Illness and Substance Use Disorder Services</b>			
<b>Inpatient Hospital Services</b> – Semi-private room		20% after Ded	40% after Ded
<b>Partial Hospitalization</b>		20% after Ded	40% after Ded
<b>Residential Treatment Centers</b> - Limited to 60 days per Covered Person per calendar year.		20% after Ded	40% after Ded
<b>Outpatient</b> (consultation, evaluation, psychotherapy only)	\$25, 3 visits free before copay*	0%	40% after Ded

<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network Copayment</b>	<b>In-Network Coinsurance</b>	<b>Out-of-Network Coinsurance</b>
<b>Outpatient</b> Other services and procedures provided in the office or outpatient facility		20% after Ded	40% after Ded
<b>Durable Medical Equipment (DME) and Medical Supplies</b>		20% after Ded	40% after Ded
<b>Prosthetic and Orthotic Devices and Services</b>		20% after Ded	40% after Ded
<b>Diabetes Management Services</b>			
Diabetic Shoes (per Medicare guidelines)		20% after Ded	40% after Ded
Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)		\$0	40% after Ded
<b>Skilled Nursing Facility</b> - (Limited to 60 Days per Covered Person per calendar year)		20% after Ded	40% after Ded
<b>Home Health Services</b> - (Limited to 50 visits per Covered Person per calendar year)		20% after Ded	40% after Ded
<b>Hospice Care</b>		20% after Ded	20% after Ded
<b>Dental Care Services</b> Damage to non-diseased teeth due to accident		20% after Ded	40% after Ded
<b>Reconstructive Surgery</b>			
Correct defects due to Accident or Surgery.		20% after Ded	Not Covered
<b>Reduction Mammoplasty</b>		20% after Ded	Not Covered
<b>Pediatric Vision</b> - Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year)		20% after Ded	40% after Ded
<b>Medications</b>			
Hospital or Ambulatory Surgical Center		20% after Ded	40% after Ded
Physician's Office (PCP only)	\$25	0%	40% after Ded
Retail Pharmacy (Drug Store)			
Preventive Medications	\$0	0%	Not Covered
Generic Medications	\$15	0%	Not Covered
Preferred Brand Name Medications	\$40	0%	Not Covered
Non-Preferred Brand Name Medications	\$70	0%	Not Covered
Specialty Pharmacy (Prior Approval Required)			
Preferred Specialty Medications	\$140	0%	Not Covered
Non-Preferred Specialty Medications	\$280	0%	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications		20% after Ded	40% after Ded
<b>Organ Transplant Services</b>		20% after Ded	40% after Ded
<b>Medical Disorder Requiring Specialized Nutrients and Formulas</b>		20% after Ded	40% after Ded

<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network Copayment</b>	<b>In-Network Coinsurance</b>	<b>Out-of-Network Coinsurance</b>
<b>Hearing Aid Benefits</b> - \$1,400 per Ear per Covered Person.		0%	0%
<b>Temporomandibular Joint Benefits</b>		20% after Ded	40% after Ded
<b>Miscellaneous Health Interventions</b>		20% after Ded	40% 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.*