Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Small Group Silver 3000 Elite
Schedule of Benefits

This Schedule of Benefits is part of the Evidence of Coverage, Form 31-26 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

Lifetime Maximum – per Member (all services)	No Lifetime Maximum
Dependent Age	26

	In-Network	Out-of-Network
Deductible - Individual	$3,000.00	$3,900.00
Deductible – Family	2 Members must meet their individual deductible limit	2 Members must meet their individual deductible limit
Annual Limitation on Cost Sharing - Individual	$9,100.00	$11,830.00
Annual Limitation on Cost Sharing - Family	$18,200.00	$23,660.00

**The Annual Limit on Cost Sharing can be met by payments of Coinsurance, prescription drug copayments, copayments and Deductible amounts for In-Network Provider services. It cannot be met by non-covered expenses, any Coinsurance or Deductible amounts for Out-of-Network Providers services.*

COVERED BENEFITS AND SERVICES	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Professional Services			
Primary Care Physician (PCP) Visits	$40		40% after Ded
Specialist Office Visit (consultation/evaluation only)	$85		40% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation		20%	40% after Ded
Preventive Health Services			
Immunizations (by PCP)	$0		0%
Well Baby Care – through 12 months of age (by PCP)	$0		Not Covered
Well Child Exam – over 12 months of age (by PCP)	$0		Not Covered
Physical Exams – Adults (by PCP)	$0		Not Covered
Routine Gynecological visit (PCP or GYN)	$0		Not Covered
Mammogram and Pap Smear, PSA	$0		Not Covered
Routine Vision Exam – Adult (one per visit per Adult Member every 2 years)	$0		Not Covered
Bone Density	$0		Not Covered
Colonoscopy Screening (For ages 50-75 years of age and 1 every 10 years)	$0		Not Covered
Prostate Cancer Screening (for men age 40 or older)	$0		Not Covered
Allergy Services			
Services provided by the PCP		20%	40% after Ded
Services provided by the Specialist		20%	40% after Ded
Hospital Services			
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
Emergency Care Services			
Urgent Care Office Visit (consultation/evaluation only)	$85		40% after Ded
Services and procedures provided in the Urgent Care Center other than consultation and evaluation		20%	40% after Ded
Emergency Room	20% Coinsurance after In-Network Deductible (Coverage is the same for In-Network and Out-of-Network)		
Observation Services			

Form #: 32-26 D R1/24
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COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Ambulance Services		50%	50%
Ambulatory Surgery Centers	$200	20% after Ded	40% after Ded
Outpatient Diagnostic Services			
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)		20% after Ded	40% after Ded
Advanced Diagnostic Imaging Services CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology		20% after Ded	40% after Ded
Maternity and Family Planning Services* (Prior Notification Required)			
Initial Office Visit	Primary Care Physician Copayment		
Prenatal and Postnatal Outpatient care		20% after Ded	40% after Ded
Inpatient Maternity Services		20% after Ded	40% after Ded
Infertility Counseling and Infertility Testing		50%	Not Covered
Infertility Treatment	Not Covered	Not Covered	Not Covered
Out-of-Network Newborn coverage limited to $2,000 per Member for all services (first 90 days after birth)			
Rehabilitation Services			
Inpatient Rehabilitation Services (Limited to 60 days per Member per Contract Year)		20% after Ded	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate "therapy" visits per Member per Contract Year)	$40		Not Covered
Chiropractic Services (Limited to 30 aggregate "therapy" visits per Member per Contract Year)	$85	20%	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Member per Contract Year) - No coverage in Freestanding Facilities.	$85	20%	Not Covered
Neurologic Rehabilitation Facility Services – Limited to 60 days per lifetime.		20% after Ded	40% after Ded
Habilitation Services			
Developmental Services: (Limited to a maximum of 180 units per Member per Contract Year)	$85	20%	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate "therapy" visits per Member per Contract Year)	$40		Not Covered
Chiropractic Services (Limited to 30 aggregate "therapy" visits per Member per Contract Year)	$85	20%	Not Covered
Mental Illness and Substance Use Disorder Services			
Inpatient Hospital Services – Semi-private room		20% after Ded	40% after Ded
Partial Hospitalization		20% after Ded	40% after Ded
Residential Treatment Centers (Limited to 60 days per Member per Contract Year)		20% after Ded	40% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Outpatient (consultation, evaluation, psychotherapy only)	$40, 3 visits free before copay*		40% after Ded
Outpatient Other services and procedures provided in the office or outpatient facility		20%	40% after Ded
Durable Medical Equipment (DME) and Medical Supplies		50%	50% after Ded
Prosthetic and Orthotic Devices and Services		20% after Ded	40% after Ded
Diabetes Management Services			
Diabetic Shoes (per Medicare guidelines)		20%	40% after Ded
Diabetic Self-Management Training (Allowance or Allowable Charge of $250)	$0 per program		40% after Ded
Skilled Nursing Facility (Limited to 60 Days per Member per Contract year)		20% after Ded	40% after Ded
Home Health Services (Limited to 50 visits per Member per Contract Year)		20% after Ded	40% after Ded
Hospice Care (Must be approved by Health Advantage)		20% after Ded	Not Covered
Dental Care Services Damage to non-diseased teeth due to accident		20% after Ded	40% after Ded
Reconstructive Surgery			
Correct defects due to Accident or Surgery.		20% after Ded	Not Covered
Reduction Mammoplasty		20% after Ded	Not Covered
Pediatric Vision- Annual Routine Exam	$0		
(1 pair of glasses with lenses/contacts per Contract Year)		20%	40% after Ded
Medications			
Hospital or Ambulatory Surgical Center	Applicable Copayment	20% after Ded	40% after Ded
Physician's Office (PCP only)	Applicable Copayment		40% after Ded
Retail Pharmacy (Drug Store)			
Preventive Medications	$0		Not Covered
Generic Medications	$30		Not Covered
Preferred Brand Name Medications	$65		Not Covered
Non-Preferred Brand Name Medications	$110		Not Covered
Specialty Pharmacy (Prior Approval Required)			
Preferred Specialty Medications		20%	Not Covered
Non-Preferred Specialty Medications		20%	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications		20% after Ded	40% after Ded
Organ Transplant Services		20% after Ded	Not Covered
Medical Disorder Requiring Specialized Nutrients and Formulas	Applicable Copayment	20% after Ded	40% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Hearing Aid Benefits - $1,400 per Ear per Member.		0%	0%
Temporomandibular Joint Benefits		20% after Ded	40% after Ded
Miscellaneous Health Interventions		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 Member 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 Member 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 Evidence of Coverage.

All Covered Services are subject to Health Advantage Allowance or Allowable Charge.