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

Small Group Gold 1000 Essential PPO
Schedule of Benefits

This Schedule of Benefits is part of the Benefit Certificate, Form SmGrpPPO_75293AR122_R1/26 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	$1,000.00	$3,000.00
Deductible – Family	$2,000.00	$6,000.00
Annual Limitation on Cost Sharing - Individual	$7,750.00	$23,250.00
Annual Limitation on Cost Sharing - Family	$15,500.00	$46,500.00

COVERED BENEFITS AND SERVICES	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Professional Services			
Primary Care Physician (PCP) Visits	$30	0%	40% after Ded
Specialist Office Visit (consultation/evaluation only)	$60	0%	40% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation		20% after Ded	40% 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
Prostate Cancer Screening (for men age 40 or older)	$0	0%	Not Covered
Allergy Services			
Services provided by the PCP	$30		40% after Ded
Services provided by the Specialist	$60	20% after Ded	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 Physician/Surgical Services		20% after Ded	40% after Ded
Emergency Care Services			
Urgent Care Center	$60	20% after Ded	40% after Ded
Emergency Room		20% after Ded	Same as in network
Observation Services		20% after Ded	Same as in network
Ambulance Services		20% after Ded	Same as in network
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

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 Radiology		20% after Ded	40% after Ded
Maternity and Family Planning Services* (Prior Notification Required)			
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
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 (Limited to 60 days per Covered Person per calendar year)		20% after Ded	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year)	$30	0%	Not Covered
Chiropractic Services (Limited to the Outpatient Rehabilitation Services aggregate visit limit specified above)	$60	20% after Ded	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities		20% after Ded	Not Covered
Neurologic Rehabilitation Facility Services – Limited to 60 days per lifetime– Prior Authorization required		20% after Ded	40% after Ded
Habilitation Services			
Developmental Services: (Limited to a maximum of 180 units per Covered Person per calendar year)		20% after Ded	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year)	$30	0%	Not Covered
Chiropractic Services (Limited to the Outpatient Habilitation Services aggregate visit limit specified above)	$60	20% after Ded	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 Covered Person per calendar year		20% after Ded	40% after Ded
Outpatient (consultation, evaluation, psychotherapy only)	$30, 3 visits free before copay*	0%	40% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Outpatient Other services and procedures provided in the office or outpatient facility		20% after Ded	40% after Ded
Durable Medical Equipment (DME) and Medical Supplies		20% after Ded	40% after Ded
Prosthetic and Orthotic Devices and Services		20% after Ded	40% after Ded
Diabetes Management Services			
Diabetic Shoes (per Medicare guidelines)		20% after Ded	40% after Ded
Diabetic Self-Management Training (limited to 10 hours initial instruction & additional 2 hours per calendar year)		$0	40% after Ded
Skilled Nursing Facility (Limited to 60 Days per Covered Person per calendar year)		20% after Ded	40% after Ded
Home Health Services (Limited to 50 visits per Covered Person per calendar year)		20% after Ded	40% after Ded
Hospice Care		20% after Ded	40% after Ded
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 (1pair of glasses with lenses/contacts per calendar year)		20% after Ded	40% after Ded
Medications			
Hospital or Ambulatory Surgical Center		20% after Ded	40% after Ded
Physician's Office (PCP only)	$30	0%	40% after Ded
Retail Pharmacy (Drug Store)			
Preventive Medications	$0	0%	Not Covered
Generic Medications	$20	0%	Not Covered
Preferred Brand Name Medications	$40	0%	Not Covered
Non-Preferred Brand Name Medications	$80	0%	Not Covered
Specialty Pharmacy (Prior Authorization 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	40% after Ded
Medical Disorder Requiring Specialized Nutrients and Formulas		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 hearing aid per Covered Person with unlimited replacements		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 Covered Person has a Coinsurance responsibility are subject to the In-Network Medical Annual Deductible, in most cases.

Out-of-Network Deductible and Coinsurance amounts do not apply to the In-Network Medical Annual 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.

Non-Essential Health Benefit Deductible (Non-EHB Deductible) refers to specific combined medial and drug benefit deductible for treatment that is not considered an essential health benefit. Please refer to your Plan's Policy for more information on non-essential health benefits.

Non-Essential Health Benefit Deductible amounts do not apply to the In-Network or Out-of-Network Medical Annual Deductible or Annual Limitation on Cost Sharing. Expenses incurred for non-essential health benefits may exceed the benefit limits for 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.

If an In-Network Provider is not available for covered services or supplies, you may notify the Company prior to receiving treatment to obtain prior authorization of in-network coverage for such services or supplies. If the Company determines covered services or supplies are not available from an In-Network Provider, a written authorization of in-network coverage for such services or supplies will be provided to the policyholder, then In-Network Deductible, Coinsurance, and Copayment will apply to the claims for services that you receive from the Out-of-Network Provider if authorized by the Company. See the Plan's Policy for additional information on *Provider Network and Cost Sharing Procedures.*

Please note that Prior Authorization 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.

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238- 8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملحوظة: خدمات المساعدة اللغوية متاحة لكم مجانًا، كما أن وسائل وخدمات المساعدة المناسبة لتوفير المعلومات بصيغ يسهل عليكم الوصول إليها متاحة مجانًا أيضًا. إلى مقدم الرعاية التحدث إلى أو (711 :TTY) 1-800-238-8379 :يرجى الاتصال على الرقم.

Hindi: ध्यान दें: आपके लिए निशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379 （TTY: 711） にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.