

Small Group Platinum 500 Elite PPO Schedule of Benefits

An Independent Licensee of the Blue Cross and Blue Shield Association

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-Netw	ork	Out-of-Network	
Deductible - Individual	\$500.0	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	In-Network	Out-of-Network	
	Copayment	Coinsuranc	e 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		10% after De	30% after Ded	
office other than consultation and evaluation		1070 ditor Be		
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		0%		
(one per visit per Adult Covered Person every 2	\$0		Not Covered	
years)	C O	00/	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 De	ed 30% after Ded	
Hospital Services (Prior Approval Required)				
Inpatient Services - Semi-private room		10% after De	ed 30% after Ded	
Outpatient Hospital Services		10% after De	ed 30% after Ded	
Outpatient Surgical Services		10% after De	ed 30% after Ded	
Emergency Care Services		1		
Urgent Care Center	\$40	10% after De	ed 30% after Ded	
Emergency Room		10% after De	ed Same as in network	
Observation Services		10% after De	Same as in network	
Ambulance Services		10% after De	ed Same as in network	
Ambulatory Surgery Centers (Prior Approval Required)		10% after De	ed 30% after Ded	
Outpatient Diagnostic Services				
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)		10% after De	ed 30% after Ded	

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COVERED BENEFITS AND SERVICES (CONT)	In-Network	In-Network	Out-of-Network
COVERED BENEFITO AND CERVICES (CONT)	Copayment	Coinsurance	Coinsurance
Advanced Diagnostic Imaging Services			
CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology		10% after Ded	30% after Ded
(Prior Approval Required)			
Maternity and Family Planning Services* (Prior Notifical	tion Required)		
Prenatal and Postnatal outpatient care		10% after Ded	30% after Ded
(PCP Copay may apply to the first visit only)			
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 pe	er Covered Person fo	r all services (first 9	0 days after birth)
Rehabilitation Services			
Inpatient Rehabilitation Services (Prior Approval		400/ - ft Dl	Not Ossessal
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	# 00	00/	Nat Carrage
to 30 aggregate visits per Covered Person per calendar	\$20	0%	Not Covered
year)			
Chiropractic Services (Limited to the Outpatient	0.40	400/ 5/ 5	N. (0
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		10% after Ded	Not Covered
Freestanding Facilities.			
Neurologic Rehabilitation Facility Services			
(Prior Approval Required) – Limited to 60 days per		10% after Ded	30% after Ded
lifetime.			
Habilitation Services			
Developmental Services: (Limited to a maximum of 180 units per Covered		10% after Ded	Not Covered
Person per calendar year)		10 % aller Ded	Not Covered
Outpatient Habilitation Services:			
Physical, Occupational, and Speech Therapy (Limited	\$20	0%	Not Covered
to 30 aggregate visits per Covered Person per calendar	ΨΖΟ	0 70	Not Covered
year)			
Chiropractic Services (Limited to the Outpatient Habilitation Services aggregate visit limit specified	\$40	10% after Ded	Not Covered
above)	Φ40	10 % after Ded	Not Covered
Mental Illness and Substance Use Disorder Services			
Inpatient Hospital Services (Prior Approval Required)		10% after Ded	30% after Ded
Semi-private room			0070 0.10. 200
Partial Hospitalization		10% after Ded	30% after Ded
Residential Treatment Centers (Prior Approval			
Required) Limited to 60 days per Covered Person per		10% after Ded	30% after Ded
calendar year.	000 0 2 11 5	001	000/ -5' 5
Outpatient (consultation, evaluation, psychotherapy	\$20, 3 visits free	0%	30% after Ded
only) Outpatient Other services and procedures provided in	before copay*		
the office or outpatient facility		10% after Ded	30% after Ded

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Durable Medical Equipment (DME) and Medical Supplies 10% after Ded 30% aft (Prior Approval for DME for which cost exceeds \$5,000) 10% after Ded 30% aft (Prior Approval on any device for which cost exceeds \$2,000) 20% after Ded 30% aft \$20,000 30% aft Diabetic Supplies, shoes (per Medicare guidelines) 10% after Ded 30% aft Diabetic Supplies, shoes (per Medicare guidelines) 10% after Ded 30% aft Diabetic Self-Management Training (Allowance or Allowable Charge of \$250) \$0 30% aft 30	etwork rance
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds \$20,000 \) 10% after Ded 30% aft \$20,000 \) Diabetes Management Services Diabetic Supplies, shoes (per Medicare guidelines) 10% after Ded 30% aft 10% after Ded 30	er Ded
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1 9	
except kidney and cornea transplants.)	r Ded
Medical Disorder Requiring Specialized Nutrients and Formulas (Prior Approval Required) 10% after Ded 30% after Ded	r Ded
Hearing Aid Benefits - \$1,400 per Ear per Covered Person.	i
Temporomandibular Joint Benefits (Prior Approval Required)A 10% after Ded 30% after	r Ded
Miscellaneous Health Interventions 10% after Ded 30% after 3 visits free before copay" applies to the first 3 claims of Outpatient Mental Health Services in the calendar year.	r Ded

^{*&}quot;3 visits free before copay" applies to the first 3 claims of Outpatient Mental Health Services in the calendar year.

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Fulfillment

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.