

## 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	\$5,775.00	
Annual Limitation on Cost Sharing - Family	\$3,000	.00	\$11,550.00	
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	
Prostate Cancer Screening (for men age 40 or older)	\$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				
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		
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		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	

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Fulfillment

COVEDED DENEETS AND SERVICES (CONT)	In-Network In-Network Out-of-Network			
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		10% after Ded	30% after Ded	
Maternity and Family Planning Services* (Prior Notifica	tion 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		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 (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  – Limited to 60 days per lifetime.		10% after Ded	30% after Ded	
Habilitation Services				
<b>Developmental Services:</b> (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 Semi-private room		10% after Ded	30% after Ded	
Partial Hospitalization		10% after Ded	30% after Ded	
Residential Treatment Centers - 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	

Prosthetic and Orthotic Devices and Services   10% after Ded   30% after Ded   Diabetes Management Services	COVERED BENEFITS AND SERVICES (CONT)	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Diabetes Management Services   Diabetic Shoes (per Medicare guidelines)   10% after Ded   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Properties of Self-Manage			10% after Ded	30% after Ded
Diabetic Shoes (per Medicare guidelines)   10% after Ded   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)   \$0   30% after Diabetic Self-Management Training (Allowance or Allowable Charge of Self-Diabetic Self-Diabetic Self-Management Training (Allowance or Allowable Charge of Self-Diabetic Self-	Prosthetic and Orthotic Devices and Services		10% after Ded	30% after Ded
Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)  Skilled Nursing Facility (Limited to 60 Days per Covered Person per calendar year)  Home Health Services (Limited to 50 visits per Covered Person per calendar year)  Hospice Care  Dental Care Services Damage to non-diseased teeth due to accident  Reconstructive Surgery  Correct defects due to Accident or Surgery.  Pediatric Vision- Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year)  Medications  Hospital or Ambulatory Surgical Center Physician's Office (PCP only) Retail Pharmacy (Drug Store)  Preventive Medications Preferred Brand Name Medications Specialty Pharmacy (Prior Approval Required) Perferred Specialty Medications Non-Preferred Specialty Medications Specialty Pharmacy (Prior Approval Required) Preferred Specialty Medications Non-Preferred Specialty Medications Specialty Pharmacy (Prior Approval Required) Preferred Specialty Medications Specialty Pharmacy (Prior Approval Required) Promulas  Promulas	Diabetes Management Services			
Skilled Nursing Facility - (Limited to 60 Days per Covered Person per calendar year)   10% after Ded   30% a	Diabetic Shoes (per Medicare guidelines)		10% after Ded	30% after Ded
Covered Person per calendar year)			\$0	30% after Ded
(Limited to 50 visits per Covered Person per calendar year)  Hospice Care  Dental Care Services Damage to non-diseased teeth due to accident  Reconstructive Surgery Correct defects due to Accident or Surgery.  Reduction Mammoplasty  Pediatric Vision- Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year)  Medications Hospital or Ambulatory Surgical Center Physician's Office (PCP only) Retail Pharmacy (Drug Store) Preventive Medications Solo 0% Not Covere Generic Medications Preferred Brand Name Medications Non-Preferred Brand Name Medications Specialty Pharmacy (Prior Approval Required) Preferred Specialty Medications Non-Preferred Specialty Medications Non-Preferred Specialty Medications Solo 0% Not Covere Specialty Medications Solo 0% Not C			10% after Ded	30% after Ded
Dental Care Services Damage to non-diseased teeth due to accident  Reconstructive Surgery Correct defects due to Accident or Surgery.  Reduction Mammoplasty  10% after Ded Not Covere With lenses/contacts per calendar year)  Medications Hospital or Ambulatory Surgical Center Physician's Office (PCP only) Retail Pharmacy (Drug Store) Preventive Medications Generic Medications S10 Non-Preferred Brand Name Medications S20 Non-Preferred Brand Name Medications S30 Non-Preferred Brand Name Medications S50 Non-Preferred Specialty Medications S10 O% Not Covere Specialty Pharmacy (Prior Approval Required) Preferred Specialty Medications S200 O% Not Covere Home Infusion Therapy Pharmacy - Injectable Medicat Disorder Requiring Specialized Nutrients and Formulas  Hearing Aid Bransite S1400 per Ear per Covered Medicarian Aid Bransite S1400 per Ear per Covered Medicarian Aid Bransite S1400 per Ear per Covered	(Limited to 50 visits per Covered Person per calendar		10% after Ded	30% after Ded
Damage to non-diseased teeth due to accident   10% after Ded   30% after Ded   Reconstructive Surgery   Correct defects due to Accident or Surgery.   10% after Ded   Not Covere Reduction Mammoplasty   10% after Ded   Not Covere Reduction Mammoplasty   10% after Ded   Not Covere Reduction Mammoplasty   10% after Ded   30% after Ded	Hospice Care		10% after Ded	30% after Ded
Correct defects due to Accident or Surgery.  Reduction Mammoplasty  10% after Ded  Not Covered Not Cov			10% after Ded	30% after Ded
Reduction Mammoplasty	Reconstructive Surgery		•	
Pediatric Vision- Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year)       10% after Ded       30% after D         Medications         Hospital or Ambulatory Surgical Center       10% after Ded       30% after D         Physician's Office (PCP only)       \$20       0%       30% after D         Retail Pharmacy (Drug Store)       80       0%       Not Covered         Preventive Medications       \$10       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)       \$100       0%       Not Covered         Non-Preferred Specialty Medications       \$100       0%       Not Covered         Home Infusion Therapy Pharmacy - Injectable Medications       \$200       0%       Not Covered         Medical Disorder Requiring Specialized Nutrients and Formulas       10% after Ded       30% after D         Medical Disorder Requiring Specialized Nutrients and Formulas       10% after Ded       30% after D	Correct defects due to Accident or Surgery.		10% after Ded	Not Covered
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)       \$0       0%       Not Covered         Preventive Medications       \$10       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)       \$100       0%       Not Covered         Non-Preferred Specialty Medications       \$100       0%       Not Covered         Home Infusion Therapy Pharmacy - Injectable Medications       \$200       0%       Not Covered         Organ Transplant Services       10% after Ded       30% after Ded         Medical Disorder Requiring Specialized Nutrients and Formulas       10% after Ded       30% after Ded	Reduction Mammoplasty		10% after Ded	Not Covered
Hospital or Ambulatory Surgical Center  Physician's Office (PCP only)  Retail Pharmacy (Drug Store)  Preventive Medications  Generic Medications  Preferred Brand Name Medications  Non-Preferred Brand Name Medications  Specialty Pharmacy (Prior Approval Required)  Preferred Specialty Medications  Non-Preferred Specialty Medications  Specialty Pharmacy (Prior Approval Required)  Preferred Specialty Medications			10% after Ded	30% after Ded
Physician's Office (PCP only)  Retail Pharmacy (Drug Store)  Preventive Medications  Generic Medications  Preferred Brand Name Medications  Non-Preferred Brand Name Medications  Specialty Pharmacy (Prior Approval Required)  Preferred Specialty Medications  Non-Preferred Specialty Medications  Proferred Specialty Medications  Non-Preferred Specialty Medications  Non-Preferred Specialty Medications  Proferred Specialty Medications  Non-Preferred Specialty Medications  Not Covered to the profession of the	Medications			
Retail Pharmacy (Drug Store)  Preventive Medications  Generic Medications  Preferred Brand Name Medications  Non-Preferred Brand Name Medications  Specialty Pharmacy (Prior Approval Required)  Preferred Specialty Medications  Non-Preferred Specialty Medications  Non-Preferred Specialty Medications  Non-Preferred Specialty Medications  Non-Preferred Specialty Medications  Sometime Infusion Therapy Pharmacy - Injectable Medications  Organ Transplant Services  Medical Disorder Requiring Specialized Nutrients and Formulas  Hearing Aid Reposits  \$100 0% Not Covers  \$200 0% Not Covers  \$30% after D  \$30% after D  \$30% after D	Hospital or Ambulatory Surgical Center		10% after Ded	30% after Ded
Preventive Medications \$0 0% Not Covered Generic Medications \$10 0% Not Covered Generic Medications \$10 0% Not Covered Stand 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 \$200 0% Not Covered Sections \$10% after Ded		\$20	0%	30% after Ded
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 \$200 0% Not Covered Non-Preferred Specialty Non-Preferred Specialty Non-Preferred Specialty Non-Preferred Specialty Non-Preferred Specialty Non-Preferred Specialty Non-Preferred	Retail Pharmacy (Drug Store)			
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 Non-Preferred Specialty Medications \$200 0% Not Covered None Infusion Therapy Pharmacy - Injectable Medications \$10% after Ded 30% after Ded Not Covered None Transplant Services \$10% after Ded 30% after Ded Some Transplant Services \$10% after Ded 30% after Ded Some Tormulas \$10% after Ded 30% after Ded Some Tormulas \$10% after Ded 30% after Ded Some Tormulas \$10% after Ded Some Tormulas \$1	Preventive Medications	\$0	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 None Infusion Therapy Pharmacy - Injectable Medications 10% after Ded 30% after Ded 30% after Ded Medical Disorder Requiring Specialized Nutrients and Formulas 10% after Ded 30% after	Generic Medications	\$10	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 10% after Ded 30% after Ded  Medical Disorder Requiring Specialized Nutrients and Formulas 10% after Ded 30% after Ded  Non-Preferred Specialty Medications \$200 0% Not Covered 30% after Ded 30% after	Preferred Brand Name Medications	\$30		Not Covered
Preferred Specialty Medications \$100 0% Not Covered Non-Preferred Specialty Medications \$200 0% Not Covered Non-Preferred Specialty Non-Preferred Non-Prefer	Non-Preferred Brand Name Medications	\$50	0%	Not Covered
Non-Preferred Specialty Medications \$200 0% Not Covered Home Infusion Therapy Pharmacy - Injectable Medications 10% after Ded 30% after D  Organ Transplant Services 10% after Ded 30% after D  Medical Disorder Requiring Specialized Nutrients and Formulas 10% after Ded 30% after D	Specialty Pharmacy (Prior Approval Required)			
Home Infusion Therapy Pharmacy - Injectable Medications  10% after Ded 30% after D  Organ Transplant Services  10% after Ded 30% after D  Medical Disorder Requiring Specialized Nutrients and Formulas  10% after Ded 30% after D  10% after Ded 30% after D	Preferred Specialty Medications			Not Covered
Medications     10% after Ded     30% after D       Organ Transplant Services     10% after Ded     30% after D       Medical Disorder Requiring Specialized Nutrients and Formulas     10% after Ded     30% after D	Non-Preferred Specialty Medications	\$200	0%	Not Covered
Medical Disorder Requiring Specialized Nutrients and Formulas  10% after Ded 30% after D			10% after Ded	30% after Ded
Formulas 10% after Ded 30% after D	Organ Transplant Services		10% after Ded	30% after Ded
Hearing Aid Benefits - \$1,400 per Ear per Covered		-	10% after Ded	30% after Ded
Person.	<b>Hearing Aid Benefits -</b> \$1,400 per Ear per Covered Person.		0%	0%
Temporomandibular Joint Benefits (   10% after Ded   30% after D	Temporomandibular Joint Benefits (		10% after Ded	30% after Ded
Miscellaneous Health Interventions 10% after Ded 30% after D *"3 visits free before copay" applies to the first 3 claims of Outpatient Mental Health Services in the calendar year.				30% after Ded

<sup>\*&</sup>quot;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.

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Fulfillment

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.