



This Schedule of Benefits is part of the Policy, Form 17-311 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
Medical Annual Deductible - Individual	\$5,000.00	\$13,400.00
Medical Annual Deductible – Family	\$10,000.00	\$26,800.00
Prescription Drug Annual Deductible - Individual	\$2,200.00	Not Covered
Prescription Drug Annual Deductible - Family	\$4,400.00	Not Covered
Annual Limitation on Cost Sharing - Individual	\$7,250.00	\$18,200.00
Annual Limitation on Cost Sharing - Family	\$14,500.00	\$36,400.00
COVERED BENEFITS AND SERVICES	In-Network	Out-of-Network
<b>Professional Services</b>		
Primary Care Physician (PCP) Visits	\$55 Copay	50% Coinsurance after deductible
Specialist Office Visit (consultation/evaluation only)	\$85 Copay	50% Coinsurance after deductible
Services and procedures provided in the Specialist office other than consultation and evaluation	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Preventive Health Services</b>		
Immunizations (by PCP)	\$0	Not Covered
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 – Pediatric one per visit per Covered Child each calendar year)	\$0	Not Covered
Bone Density	\$0	Not Covered
<b>Allergy Services</b>		
Services provided by the PCP	0%	50% Coinsurance after deductible
Services provided by the Specialist	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Hospital Services (Prior Approval Required)</b>		
Inpatient Services -Semi-private room.	\$1000 Copay per Day after deductible	50% Coinsurance after deductible
Outpatient Hospital Services	\$150 Copay after deductible	50% Coinsurance after deductible
Outpatient Surgical Services	\$150 Copay after deductible	50% Coinsurance after deductible
<b>Emergency Care Services</b>		
Urgent Care Center	\$85 Copay	50% Coinsurance after deductible
Emergency Room	\$300 Copay after deductible	Same as in network
Observation Services	0% Coinsurance after deductible	Same as in network

<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Ambulance Services</b>	0% Coinsurance after deductible	Same as in network
<b>Ambulatory Surgery Centers</b> (Prior Approval Required)	\$150 Copay after deductible	50% Coinsurance after deductible
<b>Outpatient Diagnostic Services</b>		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	\$55 Copay	50% Coinsurance after deductible
<b>Advanced Diagnostic Imaging Services</b> - CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology <b>(Prior Approval Required)</b>	\$245 Copay	50% Coinsurance after deductible
<b>Maternity and Family Planning Services* (Prior Notification Required)</b>		
Prenatal and Postnatal outpatient care (PCP Copay may apply to the first visit only)	0% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Maternity Services	0% Coinsurance after deductible	50% Coinsurance after deductible
Infertility Counseling and Infertility Testing	0% Coinsurance after deductible	Not Covered
Infertility Treatment (Prior Approval Required)	0% Coinsurance after deductible	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)	0% Coinsurance after deductible	Not Covered
<b>Outpatient Rehabilitation Services:</b> Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	\$55 Copay	Not Covered
<b>Cardiac Rehabilitation</b> (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities.	0% Coinsurance after deductible	Not Covered
<b>Neurologic Rehabilitation Facility Services</b> (Prior Approval Required) – Limited to 60 days per lifetime.	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Habilitation Services</b>		
<b>Developmental Services:</b> (Limited to a maximum of 180 units per Covered Person per calendar year)	0% Coinsurance after deductible	Not Covered
<b>Outpatient Habilitation Services:</b> Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	\$55 Copay	Not Covered
<b>Mental Illness and Substance Use Disorder Services</b>		
<b>Inpatient Hospital Services – Semi-private room-</b> (Prior Approval Required)	\$1000 Copay per Day after deductible	50% Coinsurance after deductible
<b>Partial Hospitalization</b>	\$150 Copay after deductible	50% Coinsurance after deductible
<b>Residential Treatment Centers</b> (Prior Approval Required) Limited to 60 days per Covered Person per calendar year.	\$1000 Copay per Day after deductible	50% Coinsurance after deductible
<b>Outpatient</b> (consultation, evaluation, psychotherapy only)	\$55 Copay	50% Coinsurance after deductible

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<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental Illness and Substance Use Disorder Services (CONT)</b>		
<b>Outpatient</b> Other services and procedures provided in office or outpatient facility	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Durable Medical Equipment (DME) and Medical Supplies</b> (Prior Approval for DME for which cost exceeds \$500)	\$55 Copay	50% Coinsurance after deductible
<b>Prosthetic and Orthotic Devices and Services</b> (Prior Approval on any device for which cost exceeds \$5,000)	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Diabetes Management Services</b>		
Diabetic Supplies, shoes (per Medicare guidelines)	0% Coinsurance after deductible	50% Coinsurance after deductible
Diabetic Self-Management Training (Allowance or Allowable Charge of \$250)	0%	50% Coinsurance after deductible
<b>Skilled Nursing Facility – (Prior Approval Required)</b> (Limited to 60 days per Covered Person per calendar year)	\$100 Copay per Day after deductible	50% Coinsurance after deductible
<b>Home Health Services (Prior Approval Required)</b> (Limited to 50 visits per Covered Person per calendar year)	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Hospice Care (Prior Approval Required)</b>	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Dental Care Services</b> Damage to non-diseased teeth due to accident	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Reconstructive Surgery (Prior Approval Required)</b>		
Correct defects due to Accident or Surgery.	0% Coinsurance after deductible	Not Covered
<b>Reduction Mammoplasty (Prior Approval Required)</b>	0% Coinsurance after deductible	Not Covered
<b>Pediatric Vision-</b> (1 pair of glasses with lenses/contacts per calendar year)	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Medications</b>		
Hospital or Ambulatory Surgical Center	0% Coinsurance after deductible	50% Coinsurance after deductible
Physician's Office (PCP only)	\$55 Copay	50% Coinsurance after deductible
Retail Pharmacy (Drug Store) or Mail Order (maintenance 90-day supply)		
Preventive Medications	\$0	Not Covered
Generic Medications	\$15 Copay(retail); \$30 Copay(mail order)	Not Covered
Preferred Brand Name Medications	\$50 Copay(retail); \$100 Copay(mail order)	Not Covered
Non-Preferred Brand Name Medications	\$100 Copay after ded (retail); \$200 Copay after ded (mail order)	Not Covered
<b>Specialty Pharmacy (Prior Approval Required)</b>		
Preferred Specialty Medications	\$200 Copay after deductible	Not Covered
Non-Preferred Specialty Medications	\$240 Copay after deductible	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Organ Transplant Services (Prior Approval Required-except kidney and cornea transplants.)</b>	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Medical Disorder Requiring Specialized Nutrients or Formulas (Prior Approval Required)</b>	0% Coinsurance after deductible	50% Coinsurance after deductible

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<b>COVERED BENEFITS AND SERVICES (CONT)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hearing Aid Benefits</b> - \$1,400 per Ear per Covered Person.	0%	0%
<b>Temporomandibular Joint Benefits</b> (Prior Approval Required)	0% Coinsurance after deductible	50% Coinsurance after deductible
<b>Miscellaneous Health Interventions</b>	0% Coinsurance after deductible	50% Coinsurance after deductible

**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 Policy.

*All Covered Services are subject to the Arkansas Blue Cross and Blue Shield Allowance or Allowable Charge.*

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