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

Silver Plan AH1 - 94% PPO
Schedule of Benefits

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	$1,648.00	$13,400.00
Medical Annual Deductible – Family	$3,296.00	$26,800.00
Prescription Drug Annual Deductible - Individual	$0.00	Not Covered
Prescription Drug Annual Deductible - Family	$0.00	Not Covered
Annual Limitation on Cost Sharing - Individual	$2,300.00	$18,200.00
Annual Limitation on Cost Sharing - Family	$4,600.00	$36,400.00

COVERED BENEFITS AND SERVICES	**In-Network**	**Out-of-Network**
Professional Services		
Primary Care Physician (PCP) Visits	$4.70 Copay	50% Coinsurance after deductible
Specialist Office Visit (consultation/evaluation only)	$4.70 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
Preventive Health Services		
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
Allergy Services		
Services provided by the PCP	0%	50% Coinsurance after deductible
Services provided by the Specialist	0% Coinsurance after deductible	50% Coinsurance after deductible
Hospital Services (Prior Approval Required)		
Inpatient Services -Semi-private room.	$0 Copay per Day after deductible	50% Coinsurance after deductible
Outpatient Hospital Services	$4.70 Copay after deductible	50% Coinsurance after deductible
Outpatient Surgical Services	$4.70 Copay	50% Coinsurance after deductible
Emergency Care Services		
Urgent Care Center	$4.70 Copay	50% Coinsurance after deductible
Emergency Room	$0 Copay	Same as in network
Non-Emergency use of an Emergency Room	$9.40 Copay	Same as in network
Observation Services	0% Coinsurance after deductible	Same as in network

COVERED BENEFITS AND SERVICES (CONT)	In-Network	Out-of-Network
Ambulance Services	0% Coinsurance after deductible	Same as in network
Ambulatory Surgery Centers (Prior Approval Required)	$4.70 Copay after deductible	50% Coinsurance after deductible
Outpatient Diagnostic Services		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	$4.70 Copay	50% Coinsurance after deductible
Advanced Diagnostic Imaging Services - CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology (Prior Approval Required)	$4.70 Copay	50% Coinsurance after deductible
Maternity and Family Planning Services* (Prior Notification Required)		
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
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)	0%Coinsurance after deductible	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	$4.70 Copay	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities.	0% Coinsurance after deductible	Not Covered
Neurologic Rehabilitation Facility Services (Prior Approval Required) – Limited to 60 days per lifetime.	0% Coinsurance after deductible	50% Coinsurance after deductible
Habilitation Services		
Developmental Services: (Limited to a maximum of 180 units per Covered Person per calendar year)	0% Coinsurance after deductible	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	$4.70 Copay	Not Covered
Mental Illness and Substance Use Disorder Services		
Inpatient Hospital Services – Semi-private room- (Prior Approval Required)	$0 Copay per Day after deductible	50% Coinsurance after deductible
Partial Hospitalization	$4.70 Copay after deductible	50% Coinsurance after deductible
Residential Treatment Centers (Prior Approval Required) Limited to 60 days per Covered Person per calendar year.	$20 Copay per Day after deductible	50% Coinsurance after deductible

COVERED BENEFITS AND SERVICES (CONT)	In-Network	Out-of-Network
Mental Illness and Substance Use Disorder Services (CONT)		
Outpatient (consultation, evaluation, psychotherapy only)	$4.70 Copay	50% Coinsurance after deductible
Outpatient Other services and procedures provided in **office** or outpatient facility	0% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval for DME for which cost exceeds $500)	$4.70 Copay	50% Coinsurance after deductible
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds $5,000)	0% Coinsurance after deductible	50% Coinsurance after deductible
Diabetes Management Services		
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
Skilled Nursing Facility – (Prior Approval Required) (Limited to 60 days per Covered Person per calendar year)	$20 Copay per Day after deductible	50% Coinsurance after deductible
Home Health Services (Prior Approval Required) (Limited to 50 visits per Covered Person per calendar year)	0% Coinsurance after deductible	50% Coinsurance after deductible
Hospice Care (Prior Approval Required)	0% Coinsurance after deductible	50% Coinsurance after deductible
Dental Care Services Damage to non-diseased teeth due to accident	0% Coinsurance after deductible	50% Coinsurance after deductible
Reconstructive Surgery (Prior Approval Required)		
Correct defects due to Accident or Surgery.	0% Coinsurance after deductible	Not Covered
Reduction Mammoplasty (Prior Approval Required)	0% Coinsurance after deductible	Not Covered
Pediatric Vision- (1 pair of glasses with lenses/contacts per calendar year)	0% Coinsurance after deductible	50% Coinsurance after deductible
Medications		
Hospital or Ambulatory Surgical Center	0% Coinsurance after deductible	50% Coinsurance after deductible
Physician's Office (PCP only)	$4.70 Copay	50% Coinsurance after deductible
Retail Pharmacy (Drug Store) or Mail Order (maintenance 90-day supply)		
Preventive Medications	$0	Not Covered
Generic Medications	$4.70 Copay (retail); $9.40 Copay (mail order)	Not Covered
Preferred Brand Name Medications	$4.70 Copay (retail); $9.40 Copay (mail order)	Not Covered
Non-Preferred Brand Name Medications	$9.40 copay (retail); $18.80 Copay (mail order)	Not Covered
Specialty Pharmacy (Prior Approval Required)		
Preferred Specialty Medications	$9.40 Copay	Not Covered
Non-Preferred Specialty Medications	$9.40 Copay	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications	0% Coinsurance after deductible	50% Coinsurance after deductible
Organ Transplant Services (Prior Approval Required- except kidney and cornea transplants.)	0% Coinsurance after deductible	50% Coinsurance after deductible

COVERED BENEFITS AND SERVICES (CONT)	In-Network	Out-of-Network
Medical Disorder Requiring Specialized Nutrients or Formulas (Prior Approval Required)	0% Coinsurance after deductible	50% Coinsurance after deductible
Hearing Aid Benefits - $1,400 per Ear per Covered Person.	0%	0%
Temporomandibular Joint Benefits (Prior Approval Required)	0% Coinsurance after deductible	50% Coinsurance after deductible
Miscellaneous Health Interventions	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.