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

Silver 3350
[HSA-qualified plan]
Schedule of Benefits

This Schedule of Benefits is part of the Policy, Form 17-283 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	$3,350.00	$6,700.00
Deductible – Family	$6,700.00	$13,400.00
Annual Limitation on Cost Sharing - Individual	$3,350.00	$6,700.00
Annual Limitation on Cost Sharing - Family	$6,700.00	$13,400.00
COVERED BENEFITS AND SERVICES	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Professional Services		
Primary Care Physician (PCP) Visits	0% after Ded	0% after Ded
Specialist Office Visit (consultation/evaluation only)	0% after Ded	0% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation	0% after Ded	0% after Ded
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
Annual Routine Gynecological visit (PCP or GYN)	0%	Not Covered
Mammogram and Pap Smear, PSA	0%	Not Covered
Routine Eye Exam – Adult (one per visit per Adult Covered Person every 2 years)	0%	Not Covered
Routine Eye Exam – Pediatric (one exam per visit per Covered Child each calendar year)	0%	Not Covered
Bone Density	0%	Not Covered
Allergy Services		
Services provided by the PCP	0% after Ded	0% after Ded
Services provided by the Specialist	0% after Ded	0% after Ded
Hospital Services		
Inpatient Services -Semi-private room.	0% after Ded	0% after Ded
Outpatient Hospital Services	0% after Ded	0% after Ded
Outpatient Surgical Services	0% after Ded	0% after Ded
Emergency Care Services		
Urgent Care Center	0% after Ded	0% after Ded
Emergency Room	0% after Ded	Same as in network
Observation Services	0% after Ded	Same as in network
Ambulance Services (Ground-limited to $1,000 / trip; Air – limited to $5,000 / trip)	0% after Ded	Same as in network
Ambulatory Surgery Centers	0% after Ded	0% after Ded
Outpatient Diagnostic Services		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	0% after Ded	0% after Ded

COVERED BENEFITS AND SERVICES	In-Network Coinsurance	Out-of-Network Coinsurance
Advanced Diagnostic Imaging Services (CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology) **Prior Approval Required**	0% after Ded	0% after Ded
Maternity and Family Planning Services*		
Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only)	0% after Ded	0% after Ded
Inpatient Maternity Services	0% after Ded	0% after Ded
Infertility Counseling and Infertility Testing	0% after Ded	Not Covered
Infertility Treatment (Prior Approval Required)	0% 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)	0% after Ded	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	0% after Ded	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities.	0% after Ded	Not Covered
Neurologic Rehabilitation Facility Services (Prior Approval Required) – Limited to 60 days per lifetime.	0% after Ded	0% after Ded
Habilitation Services		
Developmental Services: (Limited to a maximum of 180 units per Covered Person per calendar year)	0% after Ded	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	0% after Ded	Not Covered
Mental Illness and Substance Use Disorder Services		
Inpatient Hospital Services – Semi-private room	0% after Ded	0% after Ded
Partial Hospitalization	0% after Ded	0% after Ded
Residential Treatment Centers (Prior Approval Required) Limited to 60 days per Covered Person per calendar year.	0% after Ded	0% after Ded
Outpatient (consultation/evaluation only)	0% after Ded	0% after Ded
Outpatient Services and procedures provided in the Specialist office other than consultation and evaluation	0% after Ded	0% after Ded
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval for DME for which cost exceeds $5,000)	0% after Ded	0% after Ded
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds $20,000)	0% after Ded	0% after Ded
Diabetes Management Services		
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	0% after Ded	0% after Ded
Diabetic Self Management Training (Allowance or Allowable Charge of $250)	0%	0% after Ded
Skilled Nursing Facility - Prior Approval Required (Limited to 60 Days per Covered Person per calendar year)	0% after Ded	0% after Ded

COVERED BENEFITS AND SERVICES (CONT)	In-Network Coinsurance	Out-of-Network Coinsurance
Home Health Services (Limited to 50 visits per Covered Person per calendar year)	0% after Ded	0% after Ded
Hospice Care	0% after Ded	0% after Ded
Dental Care Services Damage to non-diseased teeth due to accident	0% after Ded	0% after Ded
Reconstructive Surgery		
Correct defects due to Accident or Surgery. Children age 12 years and under for specific conditions.	0% after Ded	Not Covered
Reduction Mammoplasty (Prior Approval Required)	0% after Ded	Not Covered
Pediatric Vision- 1 pair of glasses with lenses/contacts per calendar year	0% after Ded	0% after Ded
Medications		
Hospital or Ambulatory Surgical Center	0% after Ded	0% after Ded
Physician's Office (PCP only)	0% after Ded	0% after Ded
Retail Pharmacy (Drug Store)		
Preventive Medications	0% after Ded	Not Covered
Generic Medications	0% after Ded	Not Covered
Preferred Brand Name Medications	0% after Ded	Not Covered
Non-Preferred Brand Name Medications	0% after Ded	Not Covered
Specialty Pharmacy		
Preferred Specialty Medications	0% after Ded	Not Covered
Non-Preferred Specialty Medications	0% after Ded	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications	0% after Ded	0% after Ded
Organ Transplant Services (Prior Approval Required- except kidney and cornea transplants.**)**	0% after Ded	0% after Ded
Medical Foods and Low Protein Modified Food Products	0% after Ded	0% after Ded
Hearing Aid Benefits - $1,400 per Ear per Covered Person.	0%	0%
Temporomandibular Joint Benefits	0% after Ded	0% after Ded
Miscellaneous Health Interventions	0% after Ded	0% after Ded

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 is 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.