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

# Small Group Gold 4000 ELITE PPO
## Schedule of Benefits

This Schedule of Benefits is part of the Benefit Certificate, Form SmGrpPPO_75293AR122_R1/27 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 | $4,000.00 | $12,000.00 |
| **Deductible –** Family | $8,000.00 | $24,000.00 |
| **Annual Limitation on Cost Sharing -** Individual | $5,700.00 | $17,100.00 |
| **Annual Limitation on Cost Sharing -** Family | $11,400.00 | $34,200.00 |

| COVERED BENEFITS AND SERVICES | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Professional Services** | | | |
| Primary Care Physician (PCP) Visits | $25 | 0% | 40% after Ded |
| Specialist Office Visit (consultation/evaluation only) | $50 | 0% | 40% after Ded |
| Services and procedures provided in the Specialist office other than consultation and evaluation | | 20% after Ded | 40% 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 | $25 | | 40% after Ded |
| Services provided by the Specialist | $50 | 20% after Ded | 40% after Ded |
| **Hospital Services** | | | |
| Inpatient Services - Semi-private room | | 20% after Ded | 40% after Ded |
| Outpatient Hospital Services | | 20% after Ded | 40% after Ded |
| Outpatient Physician/Surgical Services | | 20% after Ded | 40% after Ded |
| **Emergency Care Services** | | | |
| Urgent Care Center | $50 | 20% after Ded | 40% after Ded |
| Emergency Room | | 20% after Ded | Same as in network |
| Observation Services | | 20% after Ded | Same as in network |
| **Ambulance Services** | | 20% after Ded | Same as in network |
| **Ambulatory Surgery Centers** | $100 | 20% after Ded | 40% after Ded |
| **Outpatient Diagnostic Services** | | | |
| Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office) | | 20% after Ded | 40% after Ded |

| 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 Radiology | | 20% after Ded | 40% after Ded |
| **Maternity and Family Planning Services*** | | | |
| Prenatal and Postnatal outpatient care (Non-Preventive Services) | | 20% after Ded | 40% after Ded |
| Preventive Prenatal, Postnatal, and Postpartum Outpatient | | 0% | Not Covered |
| Inpatient Maternity Services | | 20% after Ded | 40% after Ded |
| Infertility Counseling and Infertility Testing | | 20% after Ded | Not Covered |
| Infertility Treatment | | 20% 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) | | 20% after Ded | Not Covered |
| **Outpatient Rehabilitation Services:** Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year) | $25 | 0% | Not Covered |
| **Chiropractic Services** (Limited to the Outpatient Rehabilitation Services aggregate visit limit specified above) | $50 | 20% after Ded | Not Covered |
| **Cardiac Rehabilitation** (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities | | 20% after Ded | Not Covered |
| **Neurologic Rehabilitation Facility Services** – Limited to 60 days per year | | 20% after Ded | 40% after Ded |
| **Habilitation Services** | | | |
| **Developmental Services:** (Limited to a maximum of 180 units per Covered Person per calendar year) | | 20% after Ded | Not Covered |
| **Outpatient Habilitation Services:** Physical, Occupational, and Speech Therapy (Limited to 30 aggregate visits per Covered Person per calendar year) | $25 | 0% | Not Covered |
| **Chiropractic Services** (Limited to the Outpatient Habilitation Services aggregate visit limit specified above) | $50 | 20% after Ded | Not Covered |
| **Mental Illness and Substance Use Disorder Services** | | | |
| **Inpatient Hospital Services –** Semi-private room | | 20% after Ded | 40% after Ded |
| **Partial Hospitalization** | | 20% after Ded | 40% after Ded |
| **Residential Treatment Centers -** Limited to 60 days per Covered Person per calendar year | | 20% after Ded | 40% after Ded |
| **Outpatient** (consultation, evaluation, psychotherapy only) | $25, 3 visits free before copay* | 0% | 40% after Ded |

| COVERED BENEFITS AND SERVICES (CONT) | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Outpatient** Other services and procedures provided in the office or outpatient facility | | 20% after Ded | 40% after Ded |
| **Durable Medical Equipment (DME) and Medical Supplies** | | 20% after Ded | 40% after Ded |
| **Prosthetic and Orthotic Devices and Services** | | 20% after Ded | 40% after Ded |
| **Diabetes Management Services** | | | |
| Diabetic Shoes (per Medicare guidelines) | | 20% after Ded | 40% after Ded |
| Diabetic Self-Management Training (limited to 10 hours initial instruction & additional 2 hours per calendar year) | | $0 | 40% after Ded |
| **Skilled Nursing Facility** - (Limited to 60 Days per Covered Person per calendar year) | | 20% after Ded | 40% after Ded |
| **Home Health Services -** (Limited to 50 visits per Covered Person per calendar year) | | 20% after Ded | 40% after Ded |
| **Hospice Care** | | 20% after Ded | 40% after Ded |
| **Dental Care Services**<br>Damage to non-diseased teeth due to accident | | 20% after Ded | 40% after Ded |
| **Reconstructive Surgery** | | | |
| Correct defects due to Accident or Surgery. | | 20% after Ded | Not Covered |
| **Reduction Mammoplasty** -Prior Authorization required | | 20% after Ded | Not Covered |
| **Pediatric Vision**- Annual Routine Exam (1pair of glasses with lenses/contacts per calendar year) | | 20% after Ded | 40% after Ded |
| **Medications** | | | |
| Hospital or Ambulatory Surgical Center | | 20% after Ded | 40% after Ded |
| Physician's Office (PCP only) | $25 | 0% | 40% after Ded |
| Retail Pharmacy (Drug Store) | | | |
| Preventive Medications | $0 | 0% | Not Covered |
| Generic Medications | $20 | 0% | Not Covered |
| Preferred Brand Name Medications | $45 | 0% | Not Covered |
| Non-Preferred Brand Name Medications | $90 | 0% | Not Covered |
| Specialty Pharmacy (Prior Authorization Required) | | | |
| Preferred Specialty Medications | $180 | 0% | Not Covered |
| Non-Preferred Specialty Medications | $360 | 0% | Not Covered |
| Home Infusion Therapy Pharmacy - Injectable Medications | | 20% after Ded | 40% after Ded |
| **Organ Transplant Services** | | 20% after Ded | 40% after Ded |
| **Medical Disorder Requiring Specialized Nutrients and Formulas** | | 20% after Ded | 40% after Ded |

| COVERED BENEFITS AND SERVICES (CONT) | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Hearing Aid Benefits -** $1,400 per hearing aid per Covered Person with unlimited replacements | | 0% | 0% |
| **Temporomandibular Joint Benefits** | | 20% after Ded | 40% after Ded |
| **Miscellaneous Health Interventions** | | 20% after Ded | 40% after Ded |

*"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 Medical Annual Deductible, in most cases.

Out-of-Network Deductible and Coinsurance amounts do not apply to the In-Network Medical Annual 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.

If an In-Network Provider is not available for covered services or supplies, you may notify the Company prior to receiving treatment to obtain prior authorization of in-network coverage for such services or supplies. If the Company determines covered services or supplies are not available from an In-Network Provider, a written authorization of in-network coverage for such services or supplies will be provided to the policyholder, then In-Network Deductible, Coinsurance, and Copayment will apply to the claims for services that you receive from the Out-of-Network Provider if authorized by the Company. See the Plan's Policy for additional information on *Provider Network and Cost Sharing Procedures.*

Please note that Prior Authorization 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.*

## NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

**Spanish:** ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

**Chinese Simplified:** 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

**Chinese Traditional:** 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

**Tagalog:** PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

**French:** ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

**Vietnamese:** CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

**German:** HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238- 8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

**Korean:** 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

**Russian:** ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

**Arabic:** ملحوظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية.

**Hindi:** ध्यान दें: आपके लिए निशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

**Italian:** ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

**Portuguese:** ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

**French Creole:** ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

**Polish:** UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

**Japanese:** 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379 （TTY: 711） にお電話いただくか、医療提供者にご相談ください

## NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

**Civil Rights Coordinator**
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.