# Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Assc

Small group

## OPEN ACCESS PLAN 303X
## BlueChoice Point of Service
## Schedule of Benefits

This Schedule of Benefits is part of the Evidence of Coverage, Form 31-05 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

| | | | |
|---|---|---|---|
| **Lifetime Maximum** – per Member (all services) | Unlimited | | |
| **Dependent Age** | 26 | | |
| | **In-Network** | | **Out-of-Network** |
| **Deductible** - Individual | | $1,000 | $3,000 |
| **Deductible** – Family | | $3,000 | $9,000 |
| **COVERED BENEFITS AND SERVICES** | **Copayment** | **Coinsurance** | **Coinsurance** |
| **Annual Coinsurance Limit** - Individual | | $2,000 | $8,000 |
| **Annual Coinsurance Limit** - Family | | $6,000 | $24,000 |
| **Professional Services** | | | |
| Primary Care Physician (PCP) Visits | $25 | | 40% after Ded |
| Specialist Office Visit (consultation/evaluation only) | $35 | | 40% after Ded |
| Services and procedures provided in the Specialist office other than consultation and evaluation | | 20% | 40% after Ded |
| **Preventive Health Services** | | | |
| Immunizations (by PCP) | $0 | | $0 |
| Routine Well Baby Care - (by PCP) | $0 | | 40% after Ded |
| Routine Physical Exams - Adults (by PCP) | $0 | | 40% after Ded |
| Routine Gynecological visit (PCP or GYN) | $0 | | 40% after Ded |
| Mammogram and Pap Smear, PSA | $0 | | 40% after Ded |
| Routine Vision Exam (Specialist) (One visit per Member every 2 Years) | $0 | | 40% after Ded |
| Bone Density | $0 | | 40% after Ded |
| **Allergy Services** | | | |
| Services provided by the PCP | | 20% | 40% after Ded |
| Services provided by the Specialist | | 20% | 40% after Ded |
| **Hospital Services** | | | |
| Inpatient Services -Semi-private room. | $200 per admission | 20% after Ded and Copayment | 40% after Ded |
| Outpatient Hospital Services | | 20% after Ded | 40% after Ded |
| Outpatient Surgical Services | $100 | 20% after Ded | 40% after Ded |
| **Emergency Care Services*** ** | $100 Copayment plus 20% Coinsurance (Coverage is the same for In-Network and Out-of-Network) | | |
| Emergency Room/Urgent Care Center | | | |
| Observation Services | | | |
| Urgent Care Office Visit (consultation/evaluation only) | $35 | | 40% after Ded |
| Services and procedures provided in the Urgent Care Center other than consultation and evaluation | | 20% | 40% after Ded |
| *** ***Emergency Care Copayment waived if Member is admitted directly to the same Hospital.*** | | | |
| **Ambulance Services** (Ground - limited to $1000 / trip; Air – limited to $5000 / trip (one trip per contract year) | | 50% | 50% |
| **Ambulatory Surgery Centers** (facility Copayment applies) | $100 | 20% after Ded | 40% after Ded |
| **Outpatient Diagnostic Services** | | | |
| Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office) | Applicable Copayment | 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 MUST be Prior Approved by Health Advantage** | | | |
| Advanced Diagnostic Imaging – CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology | Applicable Copayment | 20% after Ded | 40% after Ded |
| **Maternity and Family Planning Services*** | | | |
| Prenatal and Postnatal outpatient care (Office visit Copayment may apply first visit only) | Applicable Copayment | 20% after Ded | 40% after Ded |
| Inpatient Maternity Services (Subject to all Inpatient Deductible and Coinsurance) | $200 per admission | 20% after Ded and Copayment | 40% after Ded |
| Infertility Counseling and Infertility Testing (refer to EOC) | 50% | | Not Covered |
| Infertility Treatment not covered | | | |
| ****Out-of-Network Newborn coverage limited to $2000 per Member for all services (first 90 days of birth)*** | | | |
| **Therapy Services** | | | |
| **Inpatient Rehabilitation Services** ([Limited to 60 days per member per Contract Year and ]Subject to Inpatient Hospital Deductible and Coinsurance) | $200 per admission | 20% after Ded and Copayment | Not Covered |
| **Outpatient Rehabilitation Services:** Physical, Occupational, and Speech Therapy; and Chiropractic Services [(Limited to 30 aggregate visits per Member per Contract Year)] | $35 | 20% | Not Covered |
| **Cardiac Rehabilitation** [(limited to 36 visits per Member per Contract Year)] | $35 | 20% | Not Covered |
| **Mental Health and Substance Abuse Services**** | | | |
| **Inpatient Hospital** (Limited to 7 days per Member per Contract year) | 50% | | Not Covered |
| **Partial Hospitalization** (Each day counts as one inpatient day) | 50% | | Not Covered |
| **Outpatient** (Limited to 30 visits per Member per Contract Year) | 50% | | Not Covered |
| ***Mental Health/Substance Abuse Copayments do not apply to Deductible or Annual Coinsurance Limit.* | | | |
| **Durable Medical Equipment (DME) and Medical Supplies** | 50% | | 50% after Ded |
| **Prosthetic and Orthotic Devices and Services** | | 20% after Ded] | 40% after Ded |
| **Neurologic Rehabilitation Facility Services** | $200 per admission | 20% after Ded and Copayment | 40% after Ded |
| **Diabetes Management Services** | | | |
| Diabetic Supplies, shoes (per Medicare guidelines) and equipment | 20% | | 40% after Ded |
| Diabetic Self Management Training Single visit or Multiple visits | $0 per program | | 40% after Ded |
| **Skilled Nursing Facility** [(Limited to 60 Days Per Member Per Contract Year)] | | 20% after Ded | 40% after Ded |
| **Home Health Services** [(Limited to 50 visits per Member per Contract Year)] | | 20% after Ded | 40% after Ded |
| **Hospice Care** (Must be approved by Health Advantage) | | 20% after Ded | Not Covered |
| **Dental Care Services** Damage to non-diseased teeth due to accident [(Subject to $2,000 maximum per Member per accident)] | Applicable Copayment | 20% after Ded and Copayment | 40% after Ded |

| COVERED BENEFITS AND SERVICES (CONT) | In-Network Copayment | In-Network Coinsurance | Out-of-Network Coinsurance |
|---|---|---|---|
| **Reconstructive Surgery** | | | |
| Correct defects due to Accident or Surgery. (Refer to EOC) Children age 12 years and under for specific conditions. (Defects that could have been corrected prior to coverage are not covered) | Applicable Copayment | 20% after Ded and Copayment | Not Covered |
| **Breast Mammoplasty (prior approval required)** | 50% | | Not Covered |
| **Medications** | Applicable Copayment | | |
| **Hospital or Ambulatory Surgical Center** | | 20% after Ded | 40% after Ded |
| **Physician's Office** | Applicable Copayment | 20% after Copayment | 40% after Ded |
| **Retail Pharmacy (Drug Store)** *(Not Covered unless Employer purchases retail drug benefit rider from Health Advantage)* | $15/35/55 | | |
| **Home Infusion Therapy Pharmacy - Injectable Medications** | (Contact Customer Service) | (Contact Customer Service) | (Contact Customer Service) |
| **Organ Transplant Services (Approved by Health Advantage)** | $200 per admission | 20% after Ded | Not Covered |
| **Medical Foods and Low Protein Modified Food Products (Only covered in connection with specific diagnoses. See Subsection 3.24)** | Applicable Copayment | 20% after Ded | 40% after Ded |
| **Complications of Smallpox Vaccine** | Applicable Copayment | 20% after Ded | 40% after Ded |
| **Miscellaneous Health Interventions specified in Subsection 3.28** | Applicable Copayment | 20% after Ded | 40% after Ded |

***Twelve months Preexisting Condition Limitation applicable to new enrollees and dependents over the age of 18***

**NOTE:** Some In-Network Services for which the Member has a Coinsurance responsibility are subject to the In-Network Deductible. Out-of-Network Deductible, Copayment and Coinsurance amounts do not apply to the In-Network Deductible or Annual Coinsurance Limit. Expenses incurred for services that exceed specific benefit limits are not applied to the Annual Coinsurance Limit. No referral is necessary for In-Network services or Emergency Care.

To receive services at the In-Network benefit level from Out-of-Network providers, services must be arranged by an In-Network Provider and authorized by Health Advantage. The Member is responsible for difference between billed charges and the Allowance or Allowable Charges for services covered at the Out-of-Network benefit level.

*All Covered Services are subject to the Health Advantage Allowance or Allowable Charge.*