Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Silver AH1-AHCIP POS-11
Schedule of Benefits

This Schedule of Benefits is part of the Evidence of Coverage, Form 31-32 and is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

Lifetime Maximum – per Member (all services)	No Lifetime Maximum	
Dependent Age	26	
	In-Network	**Out-of-Network**
Medical Annual Deductible - Individual	$0.00	$13,400.00
Prescription Drug Annual Deductible - Individual	$0.00	Not Covered
Annual Limitation on Cost Sharing - Individual	$540.00 ($135.00 per quarter)	$18,200.00
COVERED BENEFITS AND SERVICES	**In-Network**	**Out-of-Network**
Professional Services		
Primary Care Physician (PCP) Visits	$4.70 Copay	30% Coinsurance after deductible
Specialist Office Visit (consultation/evaluation only)	$4.70 Copay	30% Coinsurance after deductible
Services and procedures provided in the Specialist office other than consultation and evaluation	0% Coinsurance	30% 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	$4.70 Copay	30% Coinsurance after deductible
Services provided by the Specialist	$4.70 Copay	30% Coinsurance after deductible
Hospital Services (Prior Approval Required)		
Inpatient Services -Semi-private room.	$0 Copay per day	30% Coinsurance after deductible
Outpatient Hospital Services	$4.70 Copay	30% Coinsurance after deductible
Outpatient Surgical Services	$4.70 Copay	30% Coinsurance after deductible
Emergency Care Services		
Urgent Care Center	$4.70 Copay	30% 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	Same as in network
Ambulance Services	0% Coinsurance	Same as in network
Ambulatory Surgery Centers (Prior Approval Required)	$4.70 Copay	30% Coinsurance after deductible
Outpatient Diagnostic Services		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	$4.70 Copay	30% Coinsurance after deductible

COVERED BENEFITS AND SERVICES (CONT.)	In-Network	Out-of-Network
Advanced Diagnostic Imaging Services CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology **Prior Approval Required**	$4.70 Copay	30% Coinsurance after deductible
Maternity and Family Planning Services* (Prior Notification Required)		
Prenatal and Postnatal outpatient care	0% Coinsurance	30% Coinsurance after deductible
Inpatient Maternity Services	0% Coinsurance	30% Coinsurance after deductible
Infertility Counseling and Infertility Testing	0% Coinsurance	Not Covered
Infertility Treatment	Not Covered	Not Covered
Out-of-Network Newborn coverage limited to $2,000 per Member for all services (first 90 days after birth)		
Rehabilitation Services		
Inpatient Rehabilitation Services (Limited to 60 days per Member per calendar year)	0% Coinsurance	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Member per calendar year)	$4.70 Copay	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Member per calendar year) - No coverage in Freestanding Facilities.	0% Coinsurance	Not Covered
Neurologic Rehabilitation Facility Services (Prior Approval Required) – Limited to 60 days per lifetime.	0% Coinsurance	30% Coinsurance after deductible
Habilitation Services		
Developmental Services: (Limited to a maximum of 180 units per Member per calendar year)	0% Coinsurance	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Member 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	30% Coinsurance after deductible
Partial Hospitalization	0% Coinsurance	30% Coinsurance after deductible
Residential Treatment Centers (Prior Approval Required) Limited to 60 days per Member per calendar year.	$20 Copay per day	30% Coinsurance after deductible
Outpatient (consultation, evaluation, psychotherapy only)	$4.70 Copay	30% Coinsurance after deductible
Outpatient Other services and procedures provided in office or outpatient facility	0% Coinsurance	30% Coinsurance after deductible
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval for DME for which cost exceeds $500)	$4.70 Copay	30% Coinsurance after deductible
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds $5,000)	$4.70 Copay	30% Coinsurance after deductible
Diabetes Management Services		
Diabetic Supplies, shoes (per Medicare guidelines)	0% Coinsurance	30% Coinsurance after deductible
Diabetic Self-Management Training (Allowance or Allowable Charge of $250)	0% Coinsurance	30% Coinsurance after deductible
Skilled Nursing Facility -Prior Approval Required (Limited to 60 Days per Member per calendar year)	$20 Copay per day	30% Coinsurance after deductible

COVERED BENEFITS AND SERVICES (CONT.)	In-Network	Out-of-Network
Home Health Services (Prior Approval Required) (Limited to 50 visits per Member per calendar year)	$4.70 Copay	30% Coinsurance after deductible
Hospice Care (Prior Approval Required)	0% Coinsurance	30% Coinsurance after deductible
Dental Care Services Damage to non-diseased teeth due to accident	$4.70 Copay	30% Coinsurance after deductible
Reconstructive Surgery (Prior Approval Required)		
Correct defects due to Accident or Surgery.	0% Coinsurance	Not Covered
Reduction Mammoplasty (Prior Approval Required)	0% Coinsurance	Not Covered
Pediatric Vision- 1 pair of glasses with lenses/contacts per calendar year	0% Coinsurance	30% Coinsurance after deductible
Medications		
Hospital or Ambulatory Surgical Center	0% Coinsurance	30% Coinsurance after deductible
Physician's Office (PCP only)	$4.70 Copay	30% 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	$4.70 Copay	30% Coinsurance after deductible
Organ Transplant Services (Prior Approval Required- except kidney and cornea transplants.)	0% Coinsurance	30% Coinsurance after deductible
Medical Disorder Requiring Specialized Nutrients or Formulas (Prior Approval Required)	0% Coinsurance	30% Coinsurance after deductible
Hearing Aid Benefits - $1,400 per Ear per Member.	0%	0%
Temporomandibular Joint Benefits (Prior Approval Required)	0% Coinsurance	30% Coinsurance after deductible
Miscellaneous Health Interventions	0% Coinsurance	30% Coinsurance after deductible

NOTE:

In-Network Services for which the Member 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 Member 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 Evidence of Coverage.

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