

Benefits Summary

Small Group PPO 100/90/70

Benefits	In-Network ¹	Out-of-Network ²		Options
Deductible	N/A	Individual \$250 \$500 \$1,000 \$2,500	Family \$500 \$1,000 \$2,000 \$5,000	
Coinsurance	10%	30%		
Coinsured Charge Limit	\$10,000 per individual per calendar year. The family limit is twice the individual limit.	\$10,000 per individual per calendar year. The family limit is twice the individual limit.		
Lifetime Maximum	Unlimited	Unlimited		
Dependent Children	To age 19; full-time students to age 23	To age 19; full-time students to age 23		
Home/Office/Outpatient Care	Member Pays	Member Pays		
Home/Office Visit Copayment	10% Coinsurance	Deductible & Coinsurance		
Preventative Care (including Annual Physical Exam and Well Woman Care)	10% Coinsurance	Deductible & Coinsurance does not apply. Limited to \$300 per calendar year.		
Well Child Care (includes necessary immunizations)	10% Coinsurance	Deductible & Coinsurance does not apply (Age 0-1 limited to \$500 per calendar year. Over age 1 limited to \$300 per calendar year.)		
Emergency Room/Facility	\$50 Copayment (waived if admitted within 24 hours)	\$50 Copayment (waived if admitted within 24 hours)		
Home/Office Visit Copayment—Specialist	10% Coinsurance	Deductible & Coinsurance		
Surgery, Pre-surgical Testing, Anesthesia	10% Coinsurance	Deductible & Coinsurance		
Maternity Care	\$0	Deductible & Coinsurance		
Laboratory Tests, X-rays	10% Coinsurance	Deductible & Coinsurance		
Allergy Testing & Treatment	10% Coinsurance	Deductible & Coinsurance		
Therapeutic Manipulation (Up to 30 visits per calendar year)	10% Coinsurance	Deductible & Coinsurance		
Home Health Care ³ (Unlimited medically necessary visits)	10% Coinsurance	Deductible & Coinsurance		
Home Infusion Therapy ³	10% Coinsurance	Deductible & Coinsurance		
Hospice Care ³ (Unlimited medically necessary visits)	10% Coinsurance	Deductible & Coinsurance		
Nutritional Counseling ³	10% Coinsurance	Deductible & Coinsurance		
Physical Therapy	10% Coinsurance	Deductible & Coinsurance		
Occupational Therapy (Physical Therapy and Occupational Therapy is limited to 30 days per calendar year combined, both in and out of network)	10% Coinsurance	Deductible & Coinsurance		
Cognitive Rehabilitation Therapy	10% Coinsurance	Deductible & Coinsurance		
Speech Therapy (Cognitive Rehabilitation Therapy and Speech Therapy is limited to 30 days per calendar year combined, both in and out of network)	10% Coinsurance	Deductible & Coinsurance		



1. A network provider delivers care.
 2. Subject to balance billing over allowed amount. Out-of-Network services are those from a provider that does not participate with WellChoice. (This does not apply to emergency benefits). Charges over WellChoice's allowed amount are not included in the Coinsured Charge Limit.
 3. Precertification by our Medical Management Program is required or treatment is not covered, except for inpatient care for which a penalty will apply.
 4. Precertification by our Behavioral Health Care Management Program is required or penalties will apply.
 Note: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with our Medical Management Program or Behavioral Health Care Management Program requirements could result in benefit reductions or denial of benefits.
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