



www.chcga.com

1100 Circle 75 Parkway, Suite 1400, Atlanta, GA 30339

800-470-2004 or 678-202-2100

Choice Select

\$3,500

SCHEDULE OF BENEFITS

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BENEFITS

MEMBER PAYS

	In Network	Out of Network
Annual Deductible	Individual: \$3,500	Individual: \$7,000
	Family: \$7,000	Family: \$14,000
Annual Out-of-Pocket Maximum	Individual: NA	Individual: \$10,000
	Family: NA	Family: \$20,000
Primary Care Physician (PCP) Services - when performed and billed in a physician's office.		
Office Visits	\$35 Copay	Deductible+40%
Allergy Testing, Treatment and Injections	\$35 Copay	Deductible+40%
Chemotherapy and Radiation	\$35 Copay	Deductible+40%
Family Planning	\$35 Copay	Deductible+40%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	\$35 Copay	Deductible+40%
Radiology - <i>When test is performed in physician's office</i>	\$35 Copay	Deductible+40%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
Specialist Physician Services - when performed and billed in a physician's office.		
Office Visits	Deductible, then \$50	Deductible+40%
Allergy Testing, Treatment and Injections	Deductible, then \$50	Deductible+40%
Chemotherapy and Radiation	Deductible, then \$50	Deductible+40%
Family Planning	Deductible, then \$50	Deductible+40%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	Deductible, then \$50	Deductible+40%
Radiology - <i>When test is performed in physician's office</i>	Deductible, then \$50	Deductible+40%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
Preventive Health Services		
Annual Adult Physical	No cost to the member	Deductible+40%
Annual Well-Woman exam (<i>including annual Pap smear</i>)	No cost to the member	Deductible+40%
Immunizations and Vaccines	No cost to the member	Deductible+40%
Well Child Care / Newborn Care	No cost to the member	40% Coinsurance
Mammogram	No cost to the member	Deductible+40%
<i>This is not intended to be an all-inclusive list. Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network services.</i>		
Physician Services - When performed and billed in a physician's office		
MRIs and MRAs	Deductible, then \$50	Deductible+40%
Nuclear Stress Tests	Deductible, then \$50	Deductible+40%
Inpatient Hospital Services		
Inpatient Hospital Services	Deductible	Deductible+40%
Inpatient Rehabilitation Facility	Deductible	Deductible+40%
Physician Services	Deductible	Deductible+40%
Maternity Services		
Physician Services - <i>one time copay per pregnancy (In-Network Only)</i>	One time \$250 copay	Deductible+40%
Inpatient Maternity Care	Deductible	Deductible+40%
<i>Radiology (Ultrasound) for Maternity, when done outside physician office may result in additional member responsibility</i>		



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BENEFITS

MEMBER PAYS

	In Network	Out of Network
Outpatient Therapy Services		
Cardiac Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	Deductible, then \$50	Deductible+40%
Pulmonary Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	Deductible, then \$50	Deductible+40%
Physical and Occupational Therapies - <i>Limited to 20 visits annually (combined)</i>	Deductible, then \$50	Deductible+40%
Speech Therapy - <i>Limited to 20 visits annually</i>	Deductible, then \$50	Deductible+40%
Convenience Care Services		
Convenience Care Visit	\$35 Copay	\$35 Copay
Urgent and Emergent Care		
Urgent Care in an Urgent Care Facility	Deductible, then \$75 Copay	In-Network Deductible, then \$75 Copay
Emergency Services - <i>Copay is waived if admitted</i>	Deductible, then \$150 Copay	In-Network Deductible, then \$150 Copay
Ambulance	Deductible, then \$150 Copay	In-Network Deductible, then \$150 Copay
Outpatient Services - When performed and billed in an outpatient facility		
Advanced imaging including:		
-- MRIs and MRAs	Deductible, then \$50	Deductible+40%
-- CAT Scans	Deductible, then \$50	Deductible+40%
-- PET Scans	Deductible, then \$50	Deductible+40%
-- Nuclear Stress Tests	Deductible, then \$50	Deductible+40%
Ambulatory Surgery - <i>only facility claim; physician and ancillary providers may bill separately and thus could result in additional member responsibility</i>	Deductible	Deductible+40%
Chemotherapy and Radiation Services	Deductible	Deductible+40%
Dialysis	Deductible	Deductible+40%
Family Planning	Deductible	Deductible+40%
Laboratory Services - <i>When specimen is drawn in an outpatient facility</i>	Deductible	Deductible+40%
Radiology - <i>When test is performed in an outpatient facility</i>	Deductible, then \$50	Deductible+40%
Other Services		
Durable Medical Equipment (DME) - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Orthotics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Prosthetics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Home Health Care - <i>Limited to 60 visits annually</i>	Deductible	Deductible+40%
Hospice	Deductible	Deductible+40%
Skilled Nursing Facility - <i>Limited to 60 days annually</i>	Deductible	Deductible+40%
Infertility Services - <i>Limited to \$1,500 annual benefit maximum</i>	No cost to the member	Deductible+40%

This Schedule of Benefits is part of your Certificate of Insurance but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate. Prior authorization may be required for specific services.

- * The applicable Copayment, Deductible and/or Coinsurance applies to every physician office visit.
- * Out-of-Network Deductible and Coinsurance amounts apply to Out-of-Pocket Maximum, except for DME, Orthotics and Prosthetics.
- * Where applicable, the Deductible must be satisfied first, before Copays and Coinsurance apply.
- * All visit and day limits are counted by combining In-Network and Out-of-Network services.
- * Your deductible could be accumulated on a calendar year or contract year. Please contact your group administrator or call Customer Service for clarification.
- * Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR). The ONR is determined by a percentage of Medicare. Please see your Certificate of Insurance for more information on ONR.