



CHOICE PLUS DIRECT PAY SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Hospital Services		
Inpatient Admission	No Cost	20%
Outpatient Surgery	No Cost	20%
Ambulance Services	No Cost	20%
Emergency Room Care	\$35/visit	20%
Hospital Alternatives		
Skilled Nursing Facility	No Cost	20%
Home Health Care (200 visit limit)	\$10/visit	20%
Hospice Care- Inpatient (combined benefit of 210 days)	No Cost	20%
Hospice Care-Outpatient	\$10/visit	20%
Private Duty Nursing		
(\$5,000 maximum per calendar year (\$10,000 lifetime maximum))	\$10/visit	20%
Doctor's Services		
Allergy Testing and Treatment	\$10/visit	20%
Anesthesia	\$10/visit	20%
Delivery of Child	\$10	20%
Diagnostic Services and Treatment	\$10/visit	20%
Mammography Screening	\$10/visit	20%
Obstetrical/Gynecological Services	\$10/visit	20%
Office Visits	\$10/visit	20%
Pre-and Post-Natal Care	No Cost	20%
Radiation Therapy and Chemotherapy	\$10/visit	20%
Second Surgical Opinions	No Cost	0%
Surgical Services (per occurrence)	No Cost	20%
Well Child Care (including immunizations)	No Cost	Not Covered
X-ray and Laboratory Services	\$10/visit	20%
Rehabilitative Services		
Physical Therapy-Inpatient	No Cost	20%
Physical Therapy-Outpatient (Limited to 90 days per condition per calendar year)	\$10/visit	20%
Prescription Drugs		
\$100 deductible per individual per calendar year. \$300 per family per calendar year maximum deductible. Retail 34 day supply		
Generic	\$5	Not Covered
Brand Name	\$10	Not Covered
Mail Order- 90 day supply (may not be included in your plan)		
Generic	\$10	Not Covered
Brand name	\$20	Not Covered



CHOICE PLUS DIRECT PAY SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Alcoholism, Substance Abuse and Mental Nervous Conditions		
Mental Health-Inpatient Admission (limited to 30 days combined with Inpatient detoxification benefit)	No Cost	0%
Mental Health-Outpatient (limited to 30 visits for regular treatment and 3 visits for crisis intervention)	10%	10%
Inpatient Detoxification (limited to 30 days combined with inpatient mental health benefit)	No Cost	0%
Durable Medical Equipment	No cost	20%
Diabetic Equipment and supplies	\$10/item	20%
Prosthetic and Orthotic Devices		
Such as Prosthetic Limbs, Artificial Eyes and external Breast Prostheses	No Cost	20%
Deductibles		
Individual Per Calendar Year	None	\$1,000
Family Per Calendar Year	None	\$2,000
Maximum Out-Of-Pocket Costs		
Individual Per Calendar Year	None	\$3,000
Family Per Calendar Year	None	\$5,000
Lifetime Maximum	None	\$500,000