

# Plan Benefits – Total Choice

Effective July 1, 2024







## Summary of Total Choice benefits

This summary shows Total Choice plan benefits for many medical and behavioral health services. For a complete and detailed description of benefits and Plan provisions, see your member handbook.

- ❑ **Deductible** – The Total Choice plan deductible is \$500 for one person or \$1,000 for a family each plan year.
- ❑ **Out-of-pocket cost limits** – The **out-of-pocket maximum** (\$5,000 for one person and \$10,000 for a family) limits your costs for medical, behavioral health, and pharmacy services.
- ❑ **Allowed amounts** – All benefits shown in this summary are limited to Wellpoint’s allowed amounts. The allowed amount is the most that Wellpoint pays for a covered service.
- ❑ **Preapprovals** – Services marked with a 📞 phone symbol need to be preapproved.




## Benefits for medical care under Total Choice

Service	Your member costs
📞 Ambulances	Deductible
Anesthesia	Deductible
Bereavement counseling	Deductible and 20% coinsurance ( <i>limited to \$1,500 for a family in a plan year</i> )
Cardiac rehab programs	\$20 copay
Chemotherapy	Deductible
Chiropractic care	\$20 copay ( <i>limited to 20 visits in a plan year</i> )
Diabetic supplies	<ul style="list-style-type: none"> <li>▪ <b>Contracted suppliers:</b> Deductible</li> <li>▪ <b>Non-contracted suppliers:</b> Deductible and 20% coinsurance</li> </ul>
Dialysis	Deductible
Doctor visits	
▪ Primary care (PCP) visits	\$20 copay
▪ Specialist visits	\$45 copay
▪ Virtual care (telehealth)	\$20 copay
Doctors – other services	
▪ At an emergency room	Deductible
▪ Inpatient hospital care	Deductible
▪ Outpatient hospital care	\$45 copay
Drug screening (lab tests)	Deductible
📞 Durable medical equipment (DME)	<ul style="list-style-type: none"> <li>▪ <b>Contracted suppliers:</b> Deductible</li> <li>▪ <b>Non-contracted suppliers:</b> Deductible and 20% coinsurance</li> </ul>

Service	Your member costs
Early intervention programs	No member costs
Emergency room visits	\$100 copay and deductible
 Enteral/oral therapy	<ul style="list-style-type: none"> <li>▪ <b>Contracted suppliers:</b> Deductible</li> <li>▪ <b>Non-contracted suppliers:</b> Deductible and 20% coinsurance</li> </ul>
Eye exams (routine)	\$45 copay <i>(limited to one exam every 24 months)</i>
Eyeglasses and contact lenses	Deductible <i>(limited to the first lenses within six months after eye injury or cataract surgery)</i>
Family planning services	No member costs
Fitness reimbursement	Reimbursed up to \$100 for one person and \$200 for a family in a plan year
Hearing aids	
<ul style="list-style-type: none"> <li>▪ Age 21 and under</li> </ul>	No member costs <i>(limited to \$2,000 for each impaired ear every 24 months)</i>
<ul style="list-style-type: none"> <li>▪ Age 22 and over</li> </ul>	No member costs <i>(limited to \$1,700 for each impaired ear every 24 months)</i>
Hearing exams	No member costs <i>(but you may owe a copay for the office visit)</i>
 High-tech imaging (e.g., MRIs, CT scans, and PET scans)	
<ul style="list-style-type: none"> <li>▪ Inpatient hospital</li> </ul>	Deductible
<ul style="list-style-type: none"> <li>▪ Outpatient hospital and non-hospital-owned facilities</li> </ul>	\$100 daily copay and deductible
 Home health care	<ul style="list-style-type: none"> <li>▪ <b>Contracted providers:</b> Deductible</li> <li>▪ <b>Non-contracted providers:</b> Deductible and 20% coinsurance</li> </ul>
Home infusion therapy	<ul style="list-style-type: none"> <li>▪ <b>Contracted suppliers:</b> Deductible</li> <li>▪ <b>Non-contracted suppliers:</b> Deductible and 20% coinsurance</li> </ul>
 Hospice care	Deductible
Immunizations (vaccines)	No member costs <i>(but you may owe a copay for the office visit)</i>
 Inpatient medical care	
<ul style="list-style-type: none"> <li>▪ At a hospital or rehab facility (semi-private room)</li> </ul>	\$275 quarterly copay and deductible
<ul style="list-style-type: none"> <li>▪ At a hospital or rehab facility (medically necessary private room)</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>First 90 days:</b> \$275 quarterly copay and deductible</li> <li>▪ <b>After 90 days:</b> Dollar difference between the semi-private room rate and the private room rate</li> </ul>
Lab services	Deductible
 Occupational therapy	\$20 copay <i>(preapproval required after 30 visits except with autism diagnosis)</i>
Office visits	<i>See "Doctor visits" on page 1.</i>
Oxygen	<ul style="list-style-type: none"> <li>▪ <b>Contracted suppliers:</b> Deductible</li> <li>▪ <b>Non-contracted suppliers:</b> Deductible and 20% coinsurance</li> </ul>
Personal Emergency Response System (PERS)	
<ul style="list-style-type: none"> <li>▪ Installation</li> </ul>	Deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>
<ul style="list-style-type: none"> <li>▪ Rental</li> </ul>	Deductible and 20% coinsurance <i>(limited to \$40 a month)</i>

Service	Your member costs
📞 Physical therapy	\$20 copay ( <i>preapproval required after 30 visits except with autism diagnosis</i> )
<b>Prescription drugs</b> <i>Benefits administered by CVS Caremark.  Call 877-876-7214 for information.</i>	<ul style="list-style-type: none"> <li>▪ From a network pharmacy (30-day supply): \$10/30/65 copay</li> <li>▪ By mail order (90-day supply): \$25/75/165</li> </ul>
Preventive care	No member costs
📞 Prosthetics and orthotics	Deductible
📞 Radiation therapy	Deductible
Radiology (e.g., X-rays)	
▪ Inpatient hospital	Deductible
▪ Outpatient hospital and non-hospital-owned facilities	Deductible
Retail health clinic visits	\$20 copay
📞 Skilled nursing and long-term care facilities	Deductible and 20% coinsurance ( <i>limited to 100 days in a plan year</i> )
📞 Sleep studies	Deductible
📞 Speech therapy	\$20 copay
📞 Surgery – inpatient hospital	Deductible ( <i>you also have an inpatient copay; see “Inpatient services”</i> )
📞 Surgery – outpatient	
▪ At a hospital	\$250 quarterly copay and deductible
▪ Eye and GI (gastrointestinal) surgery at a non-hospital-owned facility	\$150 quarterly copay and deductible
▪ All other outpatient surgery at a non-hospital-owned facility	\$250 quarterly copay and deductible
▪ At a doctor’s office	Deductible ( <i>you may also owe a copay for the office visit</i> )
Tobacco cessation counseling	No member costs ( <i>limited to 300 minutes in a plan year</i> )
📞 Transplants	
▪ At a Quality Center or Designated Hospital for transplants	\$275 quarterly copay and deductible
▪ At other hospitals	\$275 quarterly copay, deductible, and 20% coinsurance
Urgent care center visits	\$20 copay
Virtual care (telehealth)	\$20 copay
Wigs (after cancer treatment)	20% coinsurance

## Benefits for behavioral health care under Total Choice

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
 Applied Behavior Analysis (ABA)	\$20 copay	Deductible and 20% coinsurance
Emergency service programs	No member costs	No member costs
 Inpatient behavioral health care		
▪ Facility charges	\$275 quarterly copay and deductible	Deductible and 20% coinsurance
▪ Professional services	No member costs	Deductible and 20% coinsurance
Medication-assisted treatment (MAT)	No member costs	No member costs
 Outpatient services	\$20 copay	Deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Therapy	\$20 copay	Deductible and 20% coinsurance
Virtual care (telehealth)	\$20 copay <i>You don't owe a copay for your first 3 visits.</i>	Deductible and 20% coinsurance