America's Choice

Physician & Ancillary RBP Plan Structure

2023 PRODUCT INFORMATION

	AMERICA'S CHOICE 100	AMERICA'S CHOICE 250	AMERICA'S CHOICE 500
MAXIMUM ANNUAL BENEFIT AMOUNT	Annual $100,000 Lifetime $500,000	Annual $250,000 Lifetime $1,250,000	Annual $500,000 Lifetime $2,500,000

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN. EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE

Rates effective as of June 1, 2023

PER COVERED PERSON (Contracted Physician)	Zero Deductible	Zero Deductible	Zero Deductible
PER COVERED PERSON (Non-Contracted Physician)	Zero Deductible	Zero Deductible	Zero Deductible
PER FAMILY UNIT (Contracted Physician)	Zero Deductible	Zero Deductible	Zero Deductible
PER FAMILY UNIT (Non- Contracted Physician)	Zero Deductible	Zero Deductible	Zero Deductible
CONTRACTED PHYSICIAN NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	Not Applicable
NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	Not Applicable
COPAYMENTS			
Primary Care Physician Office Visits (Family and General Practitioner, and Internist)	$50 per visit 10 Visit Max *(Includes all visit types)*	$50 per visit 10 Visit Max *(Includes all visit types)*	$50 per visit 10 Visit Max *(Includes all visit types)*
Specialist Office Visits			
Physical & Occupational Therapy			
Speech Therapy			
Cardiac Rehabilitation			
Outpatient Mental Health/Substance Abuse			
Prenatal/Postnatal Office Visits			
Spinal Manipulation Chiropractic			
Routine Vision Exam (One per year)			
Urgent Care			
TELEMEDICINE-General Medicine	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY
TELEMEDICINE-Behavioral Health	$25 Copay	$25 Copay	$25 Copay
TELEMEDICINE-Dermatology	$45 Copay	$45 Copay	$45 Copay

PREVENTIVE SERVICES			
ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
ADULT IMMUNIZATIONS: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
MAMMOGRAM	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
ROUTINE COLONOSCOPY	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
PHYSICIAN SERVICES: PERFORMED AND BILLED IN OFFICE			
Contracted Physician: Primary Care Physician Office visits (Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA) (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*
Non-Contracted Physician: Primary Care Physician Office visits (Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA) (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply
Contracted Physician: Specialist office visits (Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, chemotherapy, radiation, and dialysis)	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*
Non-Contracted Physician: Specialist office visits (Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, chemotherapy, radiation, and dialysis)	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY			
DIAGNOSTIC TESTING LAB, X-RAY	$50 Copay 3 Per Plan Year *Inclusive of All Specialties*	$50 Copay 3 Per Plan Year *Inclusive of All Specialties*	$50 Copay 3 Per Plan Year *Inclusive of All Specialties*
COMPLEX DIAGNOSTIC SERVICES CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine	$250 Copay 3 Per Plan Year	$250 Copay 3 Per Plan Year	$250 Copay 3 Per Plan Year
SURGICAL SERVICES Procedures & Anesthesia	$250 Copayment Per Surgery *Subject to Plan Allowable*	$250 Copayment Per Surgery *Subject to Plan Allowable*	$250 Copayment Per Surgery *Subject to Plan Allowable*

EMERGENCY / URGENT CARE			
URGENT CARE IN AN URGENT CARE FACILITY	100% After Copay Counts Toward 10 Visits/ Year *Subject to Plan Allowable*	100% After Copay Counts Toward 10 Visits/ Year *Subject to Plan Allowable*	100% After Copay Counts Toward 10 Visit /Year *Subject to Plan Allowable*
EMERGENCY ROOM SERVICES	$250 Copay *2 visit limit for ER Accident, separate 2 visit limit for ER sick*	$250 Copay *2 visit limit for ER Accident, separate 2 visit limit for ER sick*	$250 Copay *2 visit limit for ER Accident, separate 2 visit limit for ER sick*
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	100% Covered Max 2 Per Plan Year	100% Covered Max 2 Per Plan Year	100% Covered Max 2 Per Plan Year
INPATIENT HOSPITAL SERVICES			
ROOM AND BOARD Paid at the Facility's Semi-Private room rate	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*
INTENSIVE CARE UNIT Paid at the Facility's Semi-Private room rate	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*	**$1,000 Copay Per Admission** Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. *Subject to Plan Allowable*
MATERNITY SERVICES:			
ROOM AND BOARD - Limited to semi-private room rate. Dependent daughter pregnancy is not covered.	**Vaginal delivery: $250 copay** per admission. **C-Section delivery: $500 copay** per admission. *Subject to Plan Allowable*	**Vaginal delivery: $250 copay** per admission. **C-Section delivery: $500 copay** per admission. *Subject to Plan Allowable*	**Vaginal delivery: $250 copay** per admission. **C-Section delivery: $500 copay** per admission. *Subject to Plan Allowable*

THERAPIES			
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.
SPEECH THERAPY Limited to 20 visits per benefit period	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.	**$50 copayment per visit** 5 visit limit for each type of therapy.
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	**$50 copayment per visit** 5 visit limit for each type of therapy. Chiropractic x-rays are covered.	**$50 copayment per visit** 5 visit limit for each type of therapy. Chiropractic x-rays are covered.	**$50 copayment per visit** 5 visit limit for each type of therapy. Chiropractic x-rays are covered.
MENTAL HEALTH CARE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT)			
INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES Paid at the Facility's Semi-Private room rate	**$250 Per Admission** *Subject to Plan Allowable*	**$250 Per Admission** *Subject to Plan Allowable*	**$250 Per Admission** *Subject to Plan Allowable*
OUTPATIENT MENTAL HEALTHCARE SERVICES	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT FOR DETAILS)			
SUBSTANCE ABUSE REHABILITATION-INPATIENT Paid at the facility's semi-private room rate	**$250 Per Admission** *Subject to Plan Allowable*	**$250 Per Admission** *Subject to Plan Allowable*	**$250 Per Admission** *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply

OTHER SERVICES			
HOME HEALTH CARE 60 visits per benefit period	**$50 Copay per visit** $500 Maximum Benefit / Year	**$50 Copay per visit** $500 Maximum Benefit / Year	**$50 Copay per visit** $500 Maximum Benefit / Year
HOSPICE CARE Residential / Facility	**$5,000 Per Plan Year Max** *Subject to Plan Allowable*	**$5,000 Per Plan Year Max** *Subject to Plan Allowable*	**$5,000 Per Plan Year Max** *Subject to Plan Allowable*
SKILLED NURSING CARE Paid at facility's semi-private room rate and limited to 60 days per benefit period maximum	**$50 Copay per day** $5000 Maximum Benefit Per Year *Subject to Plan Allowable*	**$50 Copay per day** $5000 Maximum Benefit Per Year *Subject to Plan Allowable*	**$50 Copay per day** $5000 Maximum Benefit Per Year *Subject to Plan Allowable*
DURABLE MEDICAL EQUIPMENT (DME): Limited to 12 month rental or purchase price, whichever is less	**$50 copay per item** $500 Per Plan Year *Subject to Plan Allowable*	**$50 copay per item** $500 Per Plan Year *Subject to Plan Allowable*	**$50 copay per item** $500 Per Plan Year *Subject to Plan Allowable*
PROSTHETICS AND ORTHOTIC DEVICES Max amount of $6,500 per member/per plan year	**$50 copay per item** $2,500 Per Plan Year *Subject to Plan Allowable*	**$50 copay per item** $2,500 Per Plan Year *Subject to Plan Allowable*	**$50 copay per item** $2,500 Per Plan Year *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	*Subject to Plan Allowable*	*Subject to Plan Allowable*	*Subject to Plan Allowable*
RX BENEFIT HIGHLIGHTS			
RX COMPANY	**APS Formulary**	**APS Formulary**	**APS Formulary**
PHONE#	1-800-974-7036	1-800-974-7036	1-800-974-7036
WEBSITE	americaspharmacysource.com	americaspharmacysource.com	americaspharmacysource.com
RX COPAYMENTS			
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	APS Formulary		
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	APS Formulary		
SPECIALTY MEDS	**SPECIALITY MEDICATIONS ARE NOT COVERED BY THE PLAN. MEDICATIONS MAY BE SEPERATELY AVAILABLE THROUGH PHARMACY IMPORTATION PROGRAM (PIP) OR A PATIENT ASSISTANCE PROGRAM (PAP). AMERICA'S CHOICE WILL ASSIST MEMBERS WITH THESE APPLICATIONS.		

PRECERTIFICATION
Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, organ transplants, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. A 50% (up to $2,500) penalty will apply for not obtaining precertification.
This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.
The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan; and it is not to be considered a policy of insurance.