America's Choice

Physician & Ancillary RBP Plan Structure
2024 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 PLAN ALLOWABLE.

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, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	$50 per visit 10 Visits per Member per Plan Year (Includes all visit types)	$50 per visit 10 Visits per Member per Plan Year (Includes all visit types)	$50 per visit 10 Visits per Member per Plan Year (Includes all visit types)
Specialist Office Visits			
Physical & Occupational Therapy			
Speech Therapy			
Cardiac Rehabilitation			
Outpatient Mental Health / Substance Abuse Office Visits			
Prenatal/Postnatal Office Visits			
Spinal Manipulation Chiropractic			
Routine Vision Exam (One per year)			
Urgent Care			
TELEMEDICINE-Primary Care	ZERO COPAY	ZERO COPAY	ZERO COPAY
TELEMEDICINE-Urgent Care	ZERO COPAY	ZERO COPAY	ZERO COPAY
TELEMEDICINE-Mental Health Therapy	ZERO COPAY	ZERO COPAY	ZERO COPAY
PREVENTIVE SERVICES - Click Here for a complete list.			
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)	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
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)	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY			
DIAGNOSTIC TESTING LAB, X-RAY	$50 Copay per Visit 3 Visits per Member per plan year	$50 Copay per Visit 3 Visits per Member per plan year	$50 Copay per Visit 3 Visits per Member per plan year
COMPLEX DIAGNOSTIC SERVICES CT, MRI, US, PET & Nuclear Medicine	$250 Copay per Visit 3 Visits per Member per plan year	$250 Copay per Visit 3 Visits per Member per plan year	$250 Copay per Visit 3 Visits per Member per plan year
SURGICAL SERVICES Includes Facility, Surgeon Fees/Physician Fees and Anesthesia	$250 Copay per Surgery 3 Surgeries per plan year	$250 Copay per Surgery 3 Surgeries per plan year	$250 Copay per Surgery 3 Surgeries per plan year
EMERGENCY			
EMERGENCY ROOM/OBSERVATION Less than 24 hours	$250 Copay per Visit 2 Visit Limit - ER Accident per plan year 2 Visit Limit for ER Sick per plan year	$250 Copay per Visit 2 Visit Limit - ER Accident per plan year 2 Visit Limit for ER Sick per plan year	$250 Copay per Visit 2 Visit Limit - ER Accident per plan year 2 Visit Limit for ER Sick per plan year
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	100% Covered 2 Transports per plan year, combined	100% Covered 2 Transports per plan year, combined	100% Covered 2 Transports per plan year, combined
INPATIENT HOSPITAL SERVICES			
ROOM AND BOARD Includes Facility and Physician Fees	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable
INTENSIVE CARE UNIT Includes Facility and Physician Fees	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable
SURGICAL SERVICES (ALL FEES) Includes Facility, Surgeon Fees/Physician Fees and Anesthesia	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 10-day limit per hospitalization. Subject to Plan Allowable	$1,000 Copay per Admission Limit to 2 hospitalizations per plan year. 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.	$250 Copay per Vaginal Delivery/ $500 per C-Section Delivery, 100% Coverage for other Maternity Services	$250 Copay per Vaginal Delivery/ $500 per C-Section Delivery, 100% Coverage for other Maternity Services	$250 Copay per Vaginal Delivery/ $500 per C-Section Delivery, 100% Coverage for other Maternity Services
MENTAL HEALTH CARE SERVICES: REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT)			
INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES Paid at the Facility's Semi-Private room rate	$250 per Admission 10-day limit per hospitalization, 2 stays per year Subject to Plan Allowable	$250 per Admission 10-day limit per hospitalization, 2 stays per year Subject to Plan Allowable	$250 per Admission 10-day limit per hospitalization, 2 stays per year Subject to Plan Allowable
CANCER TREATMENT SERVICES			
INFUSION/INJECTION DRUGS	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Chemotherapy benefit)	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Chemotherapy benefit)	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Chemotherapy benefit)
CHEMOTHERAPY/RADIATION	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Infusion/Injection benefit)	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Infusion/Injection benefit)	$100 Copay per Visit $25,000 Maximum Benefit per plan year (Maximum combined with Infusion/Injection benefit)
SUBSTANCE ABUSE SERVICES: 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	$50 Copay per Visit 10 Visit per Member Maximum Benefit per plan year	$50 Copay per Visit 10 Visit per Member Maximum Benefit per plan year	$50 Copay per Visit 10 Visit per Member Maximum Benefit per plan year
OTHER SERVICES			
ALLERGY SHOTS	$50 Copay per Visit 100% AFTER COPAY, Subject to Plan Allowable	$50 Copay per Visit 100% AFTER COPAY, Subject to Plan Allowable	$50 Copay per Visit 100% AFTER COPAY, Subject to Plan Allowable
HOME HEALTH CARE	$50 Copay per Visit $500 Maximum Benefit per plan year per Member	$50 Copay per Visit $500 Maximum Benefit per plan year per Member	$50 Copay per Visit $500 Maximum Benefit per plan year per Member
HOSPICE CARE Residential / Facility	$5,000 Maximum Benefit per plan year Subject to Plan Allowable	$5,000 Maximum Benefit per plan year Subject to Plan Allowable	$5,000 Maximum Benefit per plan year Subject to Plan Allowable
SKILLED NURSING CARE Paid at facility's semi-private room rate	$50 Copay per Day $5,000 Maximum Benefit per plan year Subject to Plan Allowable	$50 Copay per Day $5,000 Maximum Benefit per plan year Subject to Plan Allowable	$50 Copay per Day $5,000 Maximum Benefit per plan 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 Maximum Benefit per plan year Subject to Plan Allowable	$50 Copay per Item $500 Maximum Benefit per plan year Subject to Plan Allowable	$50 Copay per Item $500 Maximum Benefit per plan year Subject to Plan Allowable
PROSTHETICS AND ORTHOTIC DEVICES	$50 Copay per Item $2,500 Benefit Maximum per plan year Subject to Plan Allowable	$50 Copay per Item $2,500 Benefit Maximum per plan year Subject to Plan Allowable	$50 Copay per Item $2,500 Benefit Maximum 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	**America's Pharmacy Source**	**America's Pharmacy Source**	**America's Pharmacy Source**
Phone	1-800-974-7036	1-800-974-7036	1-800-974-7036
Website	My Free Pharmacy Via America's Pharmacy Source: myfreepharmacy.com	My Free Pharmacy Via America's Pharmacy Source: myfreepharmacy.com	My Free Pharmacy Via America's Pharmacy Source: myfreepharmacy.com
Formulary	APS Formulary	APS Formulary	APS Formulary
RX COPAYMENTS			
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	ZERO COPAY		
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	ZERO COPAY		
SPECIALTY MEDICATIONS			
**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.			

PREMIUMS

	AMERICA'S CHOICE 100	AMERICA'S CHOICE 250	AMERICA'S CHOICE 500
Employee	$399.00	$449.00	$479.00
Employee + Spouse	$599.00	$639.00	$679.00
Employee + Child(ren)	$559.00	$589.00	$629.00
Family	$799.00	$849.00	$929.00