



Physician & Ancillary RBP Plan Structure
2023 PRODUCT INFORMATION

AMERICA'S CHOICE 500

MAXIMUM ANNUAL BENEFIT AMOUNT	Annual \$500,000 Lifetime \$2,500,000
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*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
PER COVERED PERSON (Non-Contracted Physician)	Zero Deductible
PER FAMILY UNIT (Contracted Physician)	Zero Deductible
PER FAMILY UNIT (Non- Contracted Physician)	Zero Deductible
CONTRACTED PHYSICIAN NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable
NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	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)
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-General Medicine	100% UNLIMITED ZERO COPAY
TELEMEDICINE-Behavioral Health	\$25 Copay
TELEMEDICINE-Dermatology	\$45 Copay

PREVENTIVE SERVICES

ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE
ADULT IMMUNIZATIONS: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria	100% OF ALLOWABLE
MAMMOGRAM	100% OF ALLOWABLE
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE
ROUTINE COLONOSCOPY	100% OF ALLOWABLE
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE



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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, <i>Subject to Plan Allowable</i>
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)	<i>Subject to Plan Allowable</i>
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, <i>Subject to Plan Allowable</i>
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)	<i>Subject to Plan Allowable</i>
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
COMPLEX DIAGNOSTIC SERVICES CT, MRI, US, PET & Nuclear Medicine	\$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
EMERGENCY	
EMERGENCY ROOM/OBSERVATION Less than 24 hours	\$250 Copay per Visit 2 Visit Limit for 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



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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. <i>Subject to Plan Allowable</i>
INTENSIVE CARE UNIT Includes Facility and Physician Fees	\$1,000 Copay per Admission Limit to 3 hospitalizations per plan year. 10-day limit per hospitalization. <i>Subject to Plan Allowable</i>
SURGICAL SERVICES (ALL FEES) Includes Facility, Surgeon Fees/Physician Fees and Anesthesia	\$1,000 Copay per Surgery Limit to 2 surgeries per Plan Year. 10-day limit per hospitalization. <i>Subject to Plan Allowable</i>
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
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 <i>Subject to Plan Allowable</i>
CANCER TREATMENT SERVICES	
INFUSION/INJECTION DRUGS	\$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)
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 <i>Subject to Plan Allowable</i>
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	\$50 Copay per Visit 10 Visit per Member Maximum Benefit per Plan Year



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OTHER SERVICES	
ALLERGY SHOTS	\$50 Copay per Visit 100% AFTER COPAY, <i>Subject to Plan Allowable</i>
HOME HEALTH CARE	\$50 Copay per Visit \$500 Maximum Benefit per Plan Year per Member
HOSPICE CARE Residential / Facility	\$5,000 Maximum Benefit per Plan Year <i>Subject to Plan Allowable</i>
SKILLED NURSING CARE Paid at facility's semi-private room rate	\$50 Copay per Day \$5,000 Maximum Benefit per Plan Year <i>Subject to Plan Allowable</i>
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 <i>Subject to Plan Allowable</i>
PROSTHETICS AND ORTHOTIC DEVICES	\$50 Copay per Item \$2,500 Benefit Maximum per Plan Year <i>Subject to Plan Allowable</i>
ALL OTHER COVERED CHARGES	<i>Subject to Plan Allowable</i>
RX BENEFIT HIGHLIGHTS	
RX COMPANY	APS Formulary
PHONE#	1-800-974-7036
WEBSITE	americaspharmacysource.com
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	\$0 Copay
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	\$0 Copay
SPECIALTY MEDICATIONS	**SPECIALITY MEDICATIONS ARE NOT COVERED BY THE PLAN. MEDICATIONS MAY BE SEPARATELY AVAILABLE THROUGH PHARMACY IMPORTATION PROGRAM (PIP) OR A PATIENT ASSISTANCE PROGRAM (PAP). AMERICA'S CHOICE WILL ASSIST MEMBERS WITH THESE APPLICATIONS.



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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

	Employee	\$479.00
	Employee + Spouse	\$679.00
	Employee + Child(ren)	\$629.00
	Family	\$929.00