America's Choice

Physician & Ancillary RBP Plan Structure

2023 PRODUCT INFORMATION

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

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
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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2023 PRODUCT INFORMATION

	AMERICA'S CHOICE 250
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*
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*
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*
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*
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.* *Subject to Plan Allowable*
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. *Subject to Plan Allowable*
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. *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
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 Plan Year. *Subject to Plan Allowable*
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 *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	$50 Copay per Visit 10 Visit per Member Maximum Benefit per Plan Year

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2023 PRODUCT INFORMATION

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OTHER SERVICES	
ALLERGY SHOTS	$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
HOSPICE CARE Residential / Facility	$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*
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*
PROSTHETICS AND ORTHOTIC DEVICES	$50 Copay per Item $2,500 Benefit Maximum per Plan Year *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	*Subject to Plan Allowable*
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.