

# IT ALWAYS SEEMS IMPOSSIBLE UNTIL IT'S DONE.

HEALTHCARE YOUR BUSINESS DESERVES

## About Us

America's Choice Health Plan includes your business in the Employer's Business Alliance, Finally, the solution to healthcare, whether you have only a few team members or a large organization your company can enjoy the benefits of big corporations.

## Why Choose Us

- ✓ Our approach is unique in that we align our incentives with you to ensure we are all working toward a common objective: to provide the highest quality healthcare at the lowest possible price.
- ✓ We offer an intuitive platform that alleviates the burden of navigating the complexities of the healthcare system without sacrificing quality.
- ✓ Each member has their own secure online personalized web portal called the Personal Health Dashboard™ (PHD). The PHD can be accessed from any device and offers many resources including: Assessments, Medical Library, Road to Wellness online behavior modification modules, Medical Records, Health Tracker, HealtheMall and much more.

## Our Free Benefits Include



### Personal Wellness

- Identity Theft
- Travel Discounts
- Relationship Services
- Get Paid to Exercise
- EAP Work-Life Benefits
- EAP Counselling
- EAP Legal Benefits
- Behavior Modification Modules



### Financial Wellness

- Lower Your Bills
- Cashback Mall
- Student Debt Relief
- 0% Payday Loan
- Get Paid to Exercise
- Shop Now, Pay Later
- EAP Financial Benefits
- Network Discounts



### Health and Well-Being

- Telemedicine
- Health Coaching
- Diabetes Care
- Affordable Medical Imaging
- Balanced Bill Services
- Patient Assistance Program
- Pre-Certification
- Utilization Review
- Drug Import Program



Physician & Ancillary RBP Plan Structure  
**2023 PRODUCT INFORMATION**

	AMERICA'S CHOICE 100	AMERICA'S CHOICE 250	AMERICA'S CHOICE 500
<b>MAXIMUM ANNUAL BENEFIT AMOUNT</b>	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**

<b>PER COVERED PERSON (Contracted Physician)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER COVERED PERSON (Non-Contracted Physician)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER FAMILY UNIT (Contracted Physician)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER FAMILY UNIT (Non- Contracted Physician)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>CONTRACTED PHYSICIAN NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR</b> (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	Not Applicable
<b>NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR</b> (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	Not Applicable

**COPAYMENTS**

<b>Primary Care Physician Office Visits</b> (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)
<b>Specialist Office Visits</b>			
<b>Physical &amp; Occupational Therapy</b>			
<b>Speech Therapy</b>			
<b>Cardiac Rehabilitation</b>			
<b>Outpatient Mental Health / Substance Abuse Office Visits</b>			
<b>Prenatal/Postnatal Office Visits</b>			
<b>Spinal Manipulation Chiropractic</b>			
<b>Routine Vision Exam (One per year)</b>			
<b>Urgent Care</b>			
<b>TELEMEDICINE</b> -General Medicine	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY
<b>TELEMEDICINE</b> -Behavioral Health	\$25 Copay	\$25 Copay	\$25 Copay
<b>TELEMEDICINE</b> -Dermatology	\$45 Copay	\$45 Copay	\$45 Copay



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**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

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*



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**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 for ER Accident per  
Plan Year. 2 Visit Limit for ER  
Sick per Plan Year

\$250 Copay per Visit  
2 Visit Limit for ER Accident per  
Plan Year. 2 Visit Limit for ER  
Sick per Plan Year

\$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

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 3 hospitalizations  
per plan year.  
10-day limit per hospitalization.  
*Subject to Plan Allowable*

\$1,000 Copay per Admission  
Limit to 3 hospitalizations  
per plan year.  
10-day limit per hospitalization.  
*Subject to Plan Allowable*

\$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*

\$1,000 Copay per Surgery Limit  
to 2 surgeries per Plan Year  
10-day limit per hospitalization  
*Subject to Plan Allowable*

\$1,000 Copay per Surgery Limit  
to 2 surgeries per Plan Year  
10-day limit per hospitalization  
*Subject to Plan Allowable*



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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




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OTHER SERVICES			
ALLERGY SHOTS	\$50 Copay per Visit 100% AFTER COPAY, <i>Subject to Plan Allowable</i>	\$50 Copay per Visit 100% AFTER COPAY, <i>Subject to Plan Allowable</i>	\$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	\$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 <i>Subject to Plan Allowable</i>	\$5,000 Maximum Benefit per Plan Year <i>Subject to Plan Allowable</i>	\$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>	\$50 Copay per Day \$5,000 Maximum Benefit per Plan Year <i>Subject to Plan Allowable</i>	\$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>	\$50 Copay per Item \$500 Maximum Benefit per Plan Year <i>Subject to Plan Allowable</i>	\$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>	\$50 Copay per Item \$2,500 Benefit Maximum per Plan Year <i>Subject to Plan Allowable</i>	\$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>	<i>Subject to Plan Allowable</i>	<i>Subject to Plan Allowable</i>



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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	<a href="https://americaspharmacysource.com">americaspharmacysource.com</a>	<a href="https://americaspharmacysource.com">americaspharmacysource.com</a>	<a href="https://americaspharmacysource.com">americaspharmacysource.com</a>
RX COPAYMENTS			
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 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