America's Choice

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

888-671-2639 Mark@InsurancePA.com

America's Choice

Rates effective June 1, 2023

$2,500/$5,000 GOLD	Age Band		
	18-44	45-54	55-62
Employee	$663.61	$688.07	$751.03
Employee + Spouse	$1,217.21	$1,266.13	$1,392.05
Employee + Child(ren)	$1,108.49	$1,152.52	$1,265.84
Family	$1,775.81	$1,849.20	$2,038.08

$5,000/$10,000 BRONZE	Age Band		
	18-44	45-54	55-62
Employee	$556.48	$576.12	$616.62
Employee + Spouse	$1,002.96	$1,042.24	$1,123.24
Employee + Child(ren)	$915.66	$951.02	$1,023.91
Family	$1,454.44	$1,513.37	$1,634.86

$5,000/$10,000 HSA	Age Band		
	18-44	45-54	55-62
Employee	$517.46	$535.35	$572.22
Employee + Spouse	$924.91	$960.68	$1,034.44
Employee + Child(ren)	$845.42	$877.62	$943.99
Family	$1,337.37	$1,391.03	$1,501.66

$7,350/$14,700 COPPER	Age Band		
	18-44	45-54	55-62
Employee	$487.81	$503.52	$535.91
Employee + Spouse	$846.87	$878.29	$943.06
Employee + Child(ren)	$777.06	$805.33	$863.63
Family	$1,210.94	$1,258.06	$1,355.22

AMERICA'S CHOICE 250	All Age Bands
Employee	$449.00
Employee + Spouse	$639.00
Employee + Child(ren)	$589.00
Family	$849.00

AMERICA'S CHOICE 500	All Age Bands
Employee	$479.00
Employee + Spouse	$679.00
Employee + Child(ren)	$629.00
Family	$929.00

America's Choice

Physician & Ancillary RBP Plan Structure
2023 PRODUCT INFORMATION

	AMERICA'S CHOICE 250	AMERICA'S CHOICE 500	$2,500/$5,000 GOLD	$5,000/$10,000 BRONZE	$5,000/$10,000 HSA	$7,350/$14,700 COPPER
MAXIMUM ANNUAL BENEFIT AMOUNT	Annual $250,000 Lifetime $1,250,000	Annual $500,000 Lifetime $2,500,000	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED

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	$2,500	$5,000	$5,000	$7,350
PER COVERED PERSON (Non-Contracted Physician)	Zero Deductible	Zero Deductible	$5,000	$10,000	$10,000	$14,700
PER FAMILY UNIT (Contracted Physician)	Zero Deductible	Zero Deductible	$5,000	$10,000	$10,000	$14,700
PER FAMILY UNIT (Non- Contracted Physician)	Zero Deductible	Zero Deductible	$10,000	$20,000	$20,000	$29,400
CONTRACTED PHYSICIAN NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700
NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	Not Applicable	Not Applicable	$20,000/$40,000	$20,000/$40,000	$20,000/$40,000	$20,000/$40,000
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)	$25 Copay	$25 Copay	20% After Deductible	$25 Copay
Specialist Office Visits			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Physical & Occupational Therapy			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Speech Therapy			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Cardiac Rehabilitation			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Outpatient Mental Health/Substance Abuse			$25 Copay	$25 Copay	20% After Deductible	$25 Copay
Prenatal/Postnatal Office Visits			$25 Copay	$25 Copay	20% After Deductible	$25 Copay
Spinal Manipulation Chiropractic			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Routine Vision Exam (One per year)			$40 Copay	$45 Copay	20% After Deductible	$45 Copay
Urgent Care			$60 Copay	$60 Copay	20% After Deductible	$60 Copay
TELEMEDICINE-General Medicine	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY	$5 Copay	$5 Copay	20% After Deductible	$5 Copay
TELEMEDICINE-Behavioral Health	$25 Copay	$25 Copay	$25 Copay	$25 Copay	20% After Deductible	$25 Copay
TELEMEDICINE-Dermatology	$45 Copay	$45 Copay	$45 Copay	$45 Copay	20% After Deductible	$45 Copay

PREVENTIVE SERVICES						
ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	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	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
MAMMOGRAM	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
ROUTINE COLONOSCOPY	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	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*	100%, AFTER COPAY, *Subject to Plan Allowable*	80%, 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	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER Non-Certified Providers DEDUCTIBLE, *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*	100%, AFTER COPAY, *Subject to Plan Allowable*	80%, 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	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*

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*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
COMPLEX DIAGNOSTIC SERVICES CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine	$250 Copay 3 Per Plan Year	$250 Copay 3 Per Plan Year	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SURGICAL SERVICES Procedures & Anesthesia	$250 Copayment Per Surgery *Subject to Plan Allowable*	$250 Copayment Per Surgery *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *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, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER COPAY, *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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	100% Covered Max 2 Per Plan Year	100% Covered Max 2 Per Plan Year	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE *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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *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.	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
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.	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
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.	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
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.	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
OUTPATIENT MENTAL HEALTHCARE SERVICES	PHCS Network Rates Apply	PHCS Network Rates Apply	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	PHCS Network Rates Apply	PHCS Network Rates Apply	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*

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	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
HOSPICE CARE Residential / Facility	**$5,000 Per Plan Year Max** *Subject to Plan Allowable*	**$5,000 Per Plan Year Max** *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
PROSTHETICS AND ORTHOTIC DEVICES Max amount of $6500 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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	*Subject to Plan Allowable*	*Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
RX BENEFIT HIGHLIGHTS						
RX COMPANY	**APS Formulary**	**APS Formulary**	**Medalist RX**	**Medalist RX**	**Medalist RX**	**APS Formulary**
PHONE#	1-800-974-7036	1-800-974-7036	855-633-2579	855-633-2579	855-633-2579	1-800-974-7036
WEBSITE	americaspharmacysource.com	americaspharmacysource.com	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	americaspharmacysource.com

RX COPAYMENTS					
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	APS Formulary	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary
		BRAND NAME FORMULARY - $45 COPAYMENT	BRAND NAME FORMULARY - $45 COPAYMENT	20% AFTER DEDUCTIBLE	
		NON-PREFERRED BRAND - $85 COPAYMENT	NON-PREFERRED BRAND - $100 COPAYMENT	20% AFTER DEDUCTIBLE	
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	APS Formulary	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary
		BRAND NAME -$90 COPAYMENT	BRAND NAME -$90 COPAYMENT	20% AFTER DEDUCTIBLE	
		NON-PREFERRED BRAND - $150 COPAYMENT	NON-PREFERRED BRAND - $150 COPAYMENT	20% AFTER DEDUCTIBLE	
SPECIALTY MEDS	**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.				

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.