



# HEALTH PLAN DETAIL COMPARISON

	AMERICA'S CHOICE 100	AMERICA'S CHOICE 250	AMERICA'S CHOICE 500
<b>BENEFIT PERIOD</b>	01/01 to 12/31	01/01 to 12/31	01/01 to 12/31
<b>MAXIMUM ANNUAL BENEFIT AMOUNT</b>	Lifetime \$500,000/\$100,000 Annual	Lifetime \$1,250,000/\$250,000 Annual	Lifetime \$2,500,000/\$500,000 Annual
<i>ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN. EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE</i>			
<b>PER COVERED PERSON (NETWORK)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER COVERED PERSON (NON-NETWORK)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER FAMILY UNIT (NETWORK)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>PER FAMILY UNIT (NON-NETWORK)</b>	Zero Deductible	Zero Deductible	Zero Deductible
<b>NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (INCLUDES DEDUCTIBLE, COINSURANCE &amp; COPAYMENTS)</b>	Not Applicable	Not Applicable	Not Applicable
<b>NON-NETWORK MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (INCLUDES DEDUCTIBLE, COINSURANCE &amp; COPAYMENTS)</b>	Not Applicable	Not Applicable	Not Applicable
<b>COPAYMENTS</b>			
<b>Primary Care Physician office visits</b>	\$50 per visit 10 Visit Max <i>(Includes all visit types)</i>	\$50 per visit 10 Visit Max <i>(Includes all visit types)</i>	\$50 per visit 10 Visit Max <i>(Includes all visit types)</i>
<b>Specialist office visits</b>			
<b>Physical &amp; Occupational Therapy</b>			
<b>Speech Therapy</b>			
<b>Cardiac Rehabilitation</b>			
<b>Outpatient Mental Health</b>			
<b>Outpatient Substance Abuse</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 - GENERAL MED</b>	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY	100% UNLIMITED ZERO COPAY
<b>TELEMEDICINE - BEHAVIORAL HEALTH</b>	\$25 Copay	\$25 Copay	\$25 Copay
<b>TELEMEDICINE - DERMATOLOGY</b>	\$40 Copay	\$40 Copay	\$40 Copay
<b>PREVENTIVE SERVICES</b>			
<b>ANNUAL ADULT PHYSICAL</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
<b>ADULT IMMUNIZATIONS: FLU, PNEUMONIA , TETANUS/DIPHTHERIA</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
<b>MAMMOGRAM</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
<b>GYNECOLOGICAL SERVICES</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
<b>ROUTINE COLONOSCOPY</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
<b>WELL CHILD CARE/NEWBORN CARE</b>	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE

PHYSICIAN SERVICES: PERFORMED AND BILLED IN OFFICE			
<b>NETWORK: Office visits to a Primary Care Physician, Family Practitioner, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner.</b> Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA.	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE	100%, AFTER COPAY, SUBJECT TO PLAN ALLOWABLE
<b>NON-NETWORK: Office visits to a Primary Care Physician, Family Practitioner, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner.</b> Includes all services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA.	PHCS NETWORK RATES APPLY	PHCS NETWORK RATES APPLY	PHCS NETWORK RATES APPLY
<b>NETWORK: Specialist office visits</b> (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
<b>NON-NETWORK: Specialist office visits</b> (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	PHCS Network Rates Apply
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY			
<b>DIAGNOSTIC TESTING (LAB, X-RAY)</b>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>
<b>COMPLEX DIAGNOSTIC SERVICES (CT SCAN, MRI, ULTRA SOUND, PET &amp; NUCLEAR MEDICINE)</b>	\$250 Copay 3 Per Plan Year	\$250 Copay 3 Per Plan Year	\$250 Copay 3 Per Plan Year
<b>SURGICAL SERVICES (PROCEDURES &amp; ANESTHESIA)</b>	\$250 Copayment Per Surgery Subject to Plan Allowable	\$250 Copayment Per Surgery Subject to Plan Allowable	\$250 Copayment Per Surgery Subject to Plan Allowable
EMERGENCY/URGENT CARE			
<b>URGENT CARE IN A URGENT CARE FACILITY</b>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>	\$50 Copay 3 Per Plan Year <i>Inclusive of All Specialties</i>
<b>EMERGENCY ROOM SERVICES</b>	\$250 Copay <i>2 visit limit for ER Accident, 2 separate visit limit for ER sick</i>	\$250 Copay <i>2 visit limit for ER Accident, 2 separate visit limit for ER sick</i>	\$250 Copay <i>2 visit limit for ER Accident, 2 separate visit limit for ER sick</i>
<b>EMERGENCY AMBULANCE SERVICES- GROUND/AIR AMBULANCE</b>	100% Covered Max 2 Per Plan Year	100% Covered Max 2 Per Plan Year	100% Covered Max 2 Per Plan Year

<b>INPATIENT HOSPITAL SERVICES</b>			
<b>ROOM AND BOARD</b> Paid at the Facility's Semi-Private room rate	\$1,000 COPAYMENT PER ADMISSION Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable	\$1,000 COPAYMENT PER ADMISSION Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable	\$1,000 COPAYMENT PER ADMISSION Limit to 2 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable
<b>INTENSIVE CARE UNIT</b> Paid at the facility's semi-private room rate	\$1,000 COPAYMENT PER ADMISSION ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable	\$1,000 COPAYMENT PER ADMISSION ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable	\$1,000 COPAYMENT PER ADMISSION ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization. Subject to Plan Allowable
<b>MATERNITY SERVICES:</b>			
<b>Room and Board</b> charges limited to semi-private room rate Dependent daughter pregnancy is not covered	<b>Vaginal delivery:</b> \$250 copayment per admission. <b>C-Section delivery:</b> \$500 copay per admission. <i>Subject to Plan Allowable</i>	<b>Vaginal delivery:</b> \$250 copayment per admission. <b>C-Section delivery:</b> \$500 copay per admission. <i>Subject to Plan Allowable</i>	<b>Vaginal delivery:</b> \$250 copayment per admission. <b>C-Section delivery:</b> \$500 copay per admission. <i>Subject to Plan Allowable</i>
<b>THERAPIES</b>			
<b>PHYSICAL &amp; OCCUPATIONAL THERAPIES</b> LIMITED TO 20 VISITS COMBINED 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.	\$50 copayment per visit 5 visit limit for each type of therapy. Chiropractic x-rays are covered.
<b>SPEECH THERAPY</b> (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.	\$50 copayment per visit 5 visit limit for each type of therapy. Chiropractic x-rays are covered.
<b>CARDIAC REHABILITATION THERAPY</b> (LIMITED TO 36 VISITS PER THERAPY , 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.	\$50 copayment per visit 5 visit limit for each type of therapy. Chiropractic x-rays are covered.
<b>CHIROPRACTIC SERVICES/SPINAL MANIPULATION</b> (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.	\$50 copayment per visit 5 visit limit for each type of therapy. Chiropractic x-rays are covered.
<b>MENTAL HEALTH CARE SERVICES (SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT))</b>			
<b>INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES</b> 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
<b>OUTPATIENT MENTAL HEALTHCARE SERVICES</b>	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply
<b>SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT FOR DETAILS)</b>			
<b>SUBSTANCE ABUSE REHABILITATION- INPATIENT</b> 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
<b>SUBSTANCE ABUSE REHABILITATION- OUTPATIENT</b>	PHCS Network Rates Apply	PHCS Network Rates Apply	PHCS Network Rates Apply

OTHER SERVICES			
<b>HOME HEALTH CARE</b> (60 VISITS PER BENEFIT PERIOD)	\$50 Copayment Per Visit \$500 Maximum Benefit Per Year	\$50 Copayment Per Visit \$500 Maximum Benefit Per Year	\$50 Copayment Per Visit \$500 Maximum Benefit Per Year
<b>HOSPICE CARE-RESIDENTIAL/FACILITY</b>	100% \$5,000 Per Plan Year Max Subject to Plan Allowable	100% \$5,000 Per Plan Year Max Subject to Plan Allowable	100% \$5,000 Per Plan Year Max Subject to Plan Allowable
<b>SKILLED NURSING CARE</b> (PAID AT FACILITY'S SEMI-PRIVATE ROOM RATE AND LIMITED TO 60 DAYS PER BENEFIT PERIOD MAXIMUM)	\$50 Copayment Per Day \$5000 Maximum Benefit Per Year Subject to Plan Allowable	\$50 Copayment Per Day \$5000 Maximum Benefit Per Year Subject to Plan Allowable	\$50 Copayment Per Day \$5000 Maximum Benefit Per Year Subject to Plan Allowable
<b>DURABLE MEDICAL EQUIPMENT (DME):</b> (Limited to 12 month rental or purchase price, whichever is less)	\$50 copayment per item \$500 Per Plan Year Subject to Plan Allowable	\$50 copayment per item \$500 Per Plan Year Subject to Plan Allowable	\$50 copayment per item \$500 Per Plan Year Subject to Plan Allowable
<b>PROSTHETICS AND ORTHOTIC DEVICES</b> Max amount of \$6500 per member/per plan year	\$50 copayment per item \$2,500 Per Plan Year Subject to Plan Allowable	\$50 copayment per item \$2,500 Per Plan Year Subject to Plan Allowable	\$50 copayment per item \$2,500 Per Plan Year Subject to Plan Allowable
<b>ALL OTHER COVERED CHARGES</b>	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
PRESCRIPTION BENEFIT HIGHLIGHTS			
<b>RX COMPANY</b>	Precision RX	Precision RX	Precision RX
<b>PHONE#</b>	1-800-974-7037	1-800-974-7037	1-800-974-7038
<b>WEBSITE</b>	<a href="https://americaspharmacysource.com/">https://americaspharmacysource.com/</a>	<a href="https://americaspharmacysource.com/">https://americaspharmacysource.com/</a>	<a href="https://americaspharmacysource.com/">https://americaspharmacysource.com/</a>
PRESCRIPTION COPAYMENTS			
<b>RETAIL PHARMACY COPAYMENTS</b> (30 DAY SUPPLY)	Precision RX Formulary	Precision RX Formulary	Precision RX Formulary
<b>MAIL ORDER OR RETAIL PHARMACY COPAYMENTS</b> (90 DAY SUPPLY)	Precision RX Formulary	Precision RX Formulary	Precision RX Formulary
<b>SPECIALTY MEDS</b>	**NON-PARTICIPATING PHARMACIES ARE NOT COVERED. ALL SPECIALITY MEDS MUST GO THROUGH FOUNDATIONAL ASSISTANCE AND INTERNATIONAL SOURCING.		
<b>PRECERTIFICATION</b>	**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			