Schedule of Benefits

2016

Understanding Your Benefits

Health Choice Insurance Co.
410 N. 44th St., Ste 900
Phoenix, AZ 85008
1-855-452-4242

HCE_2016SOB_AZ

Health Choice Value Silver 73% AV Level Silver Plan

Network: Health Choice Value

Type of Coverage: HMO

Subscriber ID: [XXXXXXX] **EOC Effective Date:** [XX/XX/XXXX]

Subscriber: [Subscriber Name] **EOC Anniversary Date:** 1/1/2016

Premium Payments: Premium payments are due on the first day of the month for which the member is purchasing coverage. Payments must be made by credit card, check, money order or automatic bank withdrawal. See the *Grace Periods and Termination of Coverage* provision in Your Evidence of Coverage (EOC) for more information. The premium amount may change without notice if the Subscriber has an Advance Premium Tax Credit and if the Health Insurance Marketplace (Marketplace) determines a change is to be made. We will make the change as directed by the Marketplace.

Network: To locate In-Network Providers and laboratories visit www.healthchoiceessential.com/Members/FindProvider.aspx and select the Network name listed at the top of this page. Health Choice Insurance Co. has two networks, one of which is designed with a smaller, more select group of Providers that results in lower premiums however, both networks meet ACA network adequacy standards. It is Your responsibility to verify that Your Provider is an In-Network Provider of the health plan You selected.

SCHEDULE OF BENEFITS

This Schedule of Benefits summarizes the coverage available under Your Health Choice Insurance Co. EOC. This Schedule of Benefits should be used with Your EOC for a complete description of Your benefits, exclusions, limitations and provisions. The following chart will assist You in identifying Your Cost Share, maximum benefits and other important information about Covered Benefits as described in Your EOC. In the event of conflict, the EOC shall prevail.

All Covered Benefits, except Emergency Services, must be provided by or through the Member's In-Network Primary Care Provider (PCP). A PCP may be a Physician of internal medicine, family practice, general practice or Pediatric medicine; or may be a Nurse Practitioner of Physician Assistant. Each Member of a family may choose a different PCP. If You need to see a Specialist, Your PCP can help You find one and must submit a Referral for Prior Authorization to Health Choice Insurance Co. Treatment by a Specialist is a Covered Benefit only after Prior Authorization. If You see a Specialist before the approved Prior Authorization is in place, You are responsible for payment of this Treatment. Female Members may see a obstetrician/gynecologist (OB/GYN) Provider without a Referral or Prior Authorization.

Your Cost Share shown in this Schedule of Benefits as Deductible, Copayment and Coinsurance indicate the amount of the Eligible Expense You are required to pay.

Prior Authorization: Specialist visits and some Covered Benefits require Prior Authorization. See Your EOC for further information regarding Prior Authorization. If You see a Specialist or receive Treatment before a required Prior Authorization is in place, You are responsible for payment of this visit and any Treatments.

Please call Our Member Services at 1-855-452-4242 for more information.

SCHEDULE OF BENEFITS	
Lifetime Maximum Benefit	Unlimited
Out-of-pocket Maximum • Per Individual Member (per Calendar Year) • Per Family maximum (per Calendar Year)	 $5,450 $10,900
Deductible • Per Individual Member (per Calendar Year) • Per Family Member (per Calendar Year)	 $2,400 $4,800

See Your Evidence of Coverage for PRIOR AUTHORIZATION requirements.

Covered Benefit Information (See *American Indians and Alaska Natives* section of the EOC For applicable Cost Share)	**Cost Share You Pay**
Primary Care Physician (PCP) Office Visits Includes: • Pediatrician, Nurse Practitioners, Physician Assistants • Medication checks for Mental Health and Substance Abuse by PCP	$15 per visit
Specialist Office Visits Includes medical, Mental Health and Substance Abuse Disorder visits.	$60 Copay per visit after deductible
Allergy / Antigen Testing Immunotherapy	$60 Copay per visit after deductible
Autism Spectrum Disorders	$60 Copay per visit after deductible
Bariatric Surgery	30% Coinsurance per visit after deductible

Covered Benefit Information	Cost Share You Pay
Chemotherapy, Radiation Therapy and Self-Administered Cancer Drugs	20% Coinsurance per visit after deductible
Chiropractic Care: Limited to twenty (20) visits per Calendar Year without Prior Approval	$60 Copay per visit after deductible
Dental Confinements and Anesthesia	20% Coinsurance per visit after deductible
Dental Services – Accident Only	20% Coinsurance per visit after deductible
Diabetes Equipment and Supplies	20% Coinsurance after deductible
Dialysis Services	20% Coinsurance per visit after deductible
Diagnostic Testing, Laboratory , Imaging and Radiology Services	20% Coinsurance per visit after deductible
Durable Medical Equipment	20% Coinsurance after deductible
Emergency Services	30% Coinsurance per visit after deductible
Emergency Transportation / Ambulance	20% Coinsurance after deductible
Habilitative Services: Limited to sixty (60) visits per Calendar Year	20% Coinsurance per visit after deductible
Hearing Aids: Limited to one (1) per ear, per Member, per Calendar Year	20% Coinsurance after deductible
Home Health Care: Limited to forty-two (42) visits per Calendar Year	20% Coinsurance per visit after deductible
Hospice Care Services	20% Coinsurance per visit after deductible
Inpatient Hospital Services Includes medical, Mental Health and Substance Abuse Disorder	30% Coinsurance per visit after deductible
Inpatient Physician and Surgical Services	30% Coinsurance after deductible
Maternity Care	20% Coinsurance per visit after deductible

Covered Benefit Information	Cost Share You Pay
Medical Foods and Amino Acid-based Formula • Amino acid-based formula for eosinophilic gastrointestinal disorder • Medical foods for inherited metabolic disorders	25% coinsurance 50% coinsurance
Orthognathic Surgery	$60 Copay after deductible
Outpatient Facility Services	30% Coinsurance after deductible
Outpatient Surgery	30% Coinsurance after deductible
Pediatric Dental and Pediatric Vision	See the Schedules provided below for these benefits.
Preventive Care	$0
Prostheses and Medical Appliances	20% Coinsurance after deductible
Reconstructive Surgery	20% Coinsurance after deductible
Rehabilitative Services: Limited to sixty (60) visits per Calendar Year • Combined total of physical, occupational, speech, cardiac and pulmonary therapy; and • Provided in an Outpatient Facility or home health setting	20% Coinsurance after deductible
Skilled Nursing Facility: Limited to ninety (90) Days per Calendar Year	20% Coinsurance after deductible
Telemedicine	$60 Copay per visit after deductible
Temporomandibular Joint (TMJ) Disorder Treatment	$60 Copay per visit after deductible
Transplant Services	20% Coinsurance per visit after deductible
Urgent Care Services	20% Coinsurance per visit after deductible

Pediatric Dental Services

Dental benefits for children 0 through 18 years of age include the following. See Your Pediatric Dental Rider for Covered Benefits and Limitations and Exclusions.

Covered Benefit Information	You Pay
Basic Treatments	$0
Intermediate Treatments	20% Coinsurance per visit after deductible
Major Treatments	20% Coinsurance per visit after deductible
Orthodontic Treatments	20% Coinsurance per visit after deductible
Anesthesia Treatments	20% Coinsurance per visit after deductible

Pediatric Vision Services

Vision care benefits for children 0 through 18 years of age include the following. See Your EOC for Covered Benefits and Limitations and Exclusions.

Covered Benefit Information	You Pay
Eye exam: One per Calendar Year. Includes dilation, if Medically Necessary	$0
Includes codes 92002/92004 New patient exams 92012/92014/92015 Established patient exams	$0
S0620 Routine ophthalmologic exam w/refraction - new patient	$0
Covered Benefit Information	**You Pay**
S0621 Routine ophthalmologic exam w/refraction - established patient	$0

Eyewear	You Pay
You may choose either prescription glasses or contacts once per Calendar Year.	
Lenses: One pair per Calendar Year. Single Vision: V2100-2199 Conventional (Lined): V2200-2299 Bifocal: V2300-2399 Conventional (Lined) Trifocal: V2121, V2221, Lenticular: V2321 **Note:** • Lenses include choice of glass or plastic lenses. • All lenses include scratch resistant coating with no additional copayment. • Fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses are not a covered benefit. • Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions ≥ +/- 6.00 diopters.	$0
Frame: One per Calendar Year: V2020 Collection Frame Non-collection frame	$0 50% Coinsurance on expenses in excess of $150
Contact Lenses: Covered once per Calendar Year in lieu of eyeglasses. V-2500-V2599	50% Coinsurance on expenses in excess of $150 (may be applied toward the cost of evaluation, materials, fitting and follow-up care)
Medically Necessary Contact Lenses: V2500-V2599	50% Coinsurance on expenses in excess of $150. Prior Authorization is required for expenses in excess of $600 for Medically Necessary contact lenses.

Optional Lenses and Treatments	You Pay
Ultraviolet Protective Coating	$0 after deductible
Polycarbonate Lenses (if not child, monocular or prescription]+/-6.00 diopters)	$30 after deductible
Blended Segment Lenses	$20 after deductible
Intermediate Vision Lenses	$30 after deductible
Standard Progressives	$0 after deductible
Premium Progressives (Varilux®, etc.)	$90 after deductible
Photochromic Glass Lenses	$20 after deductible
Plastic Photosensitive Lenses (Transitions®)	$0 after deductible
Polarized Lenses	$75 after deductible
Standard Anti-Reflective (AR) Coating	$35 after deductible
Premium AR Coating	$48 after deductible
Ultra AR Coating	$60 after deductible
Hi-Index Lenses	$55 after deductible

Low Vision

After Prior Authorization by **Health Choice Insurance Co.**, covered low vision services include the following.

- Comprehensive low vision evaluation: One every five (5) years 50% Coinsurance on expenses in excess of $150.

Follow-up care: Four (4) visits in any five-year period.

- 50% Coinsurance on expenses in excess of $150.

Prescription Drug Services:

Covered Benefit Information	You Pay
Retail Pharmacy (up to 30-day supply):	
Generic - Tier 1	$10 Copay
Preferred Brand - Tier 2	$45 Copay after deductible
Non-preferred Brand - Tier 3	50% Coinsurance after deductible
Specialty - Tier 4	50% Coinsurance after deductible
Oncology - Tier 5	20% Coinsurance after deductible
ACA Preventive - Tier 6	$0
Mail Order Pharmacy (up to a 90-day supply):	
Generic -Tier 1	$25.00 Copay
Preferred Brand - Tier 2	$112.50 Copay after deductible
Non-preferred Brand - Tier 3	50% Coinsurance after deductible
ACA Preventive - Tier 6	$0
Note: The Member cost share for oral and injectable cancer drugs is based on the Tier in which they are classified in the Formulary, but will not exceed the cost share for chemotherapy, whether administered by a health care provider or patient-administered.	

Live Healthy!
Choose Health Choice!

MEMBER SERVICES

1-855-452-4242
Monday-Friday, 6 a.m.- 6 p.m.
www.healthchoiceessential.com