



# Schedule of Benefits

## 2016

Understanding Your Benefits



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





## Health Choice Value Silver Limited Cost Sharing Plan Variation

Network: Health Choice Value

Type of Coverage: HMO

**Subscriber ID:** [XXXXXXXX]

**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](http://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 or 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.

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Health Choice Insurance Co., 410 N. 44<sup>th</sup> St. Suite 923, Phoenix, AZ 85008

Toll-free: 855-452-4242 | TTY 711 | [HealthChoiceEssential.com](http://HealthChoiceEssential.com)

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| SCHEDULE OF BENEFITS   |                     |
|--|---------------------|
| <b>Lifetime Maximum Benefit</b>  | Unlimited           |
| <b>Out-of-pocket Maximum</b> <ul style="list-style-type: none"> <li>• Per Individual Member (per Calendar Year)</li> <li>• Per Family maximum (per Calendar Year)</li> </ul> | \$6,850<br>\$13,700 |
| <b>Deductible</b> <ul style="list-style-type: none"> <li>• Per Individual Member (per Calendar Year)</li> <li>• Per Family Member (per Calendar Year)</li> </ul>             | \$2,500<br>\$5,000  |

***See Your Evidence of Coverage for PRIOR AUTHORIZATION requirements.***

| Covered Benefit Information<br>(See <i>American Indians and Alaska Natives</i> section of the EOC<br>For applicable Cost Share)   | Cost Share You Pay                         |
|---|--|
| Primary Care Physician (PCP) Office Visits<br>Includes: <ul style="list-style-type: none"> <li>• Pediatrician, Nurse Practitioners, Physician Assistants</li> <li>• Medication checks for Mental Health and Substance Abuse by PCP</li> </ul> | \$15 per visit                             |
| Specialist Office Visits<br>Includes medical, Mental Health and Substance Abuse Disorder visits.  | \$60 Copay per visit after deductible      |
| Allergy / Antigen Testing<br>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  | CostShare You Pay                          |
|--|--|
| Chemotherapy, Radiation Therapy and Self-Administered Cancer Drugs                           | 20% Coinsurance per visit after deductible |
| Chiropractic Care:<br>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<br>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   | CostShare You Pay                                    |
|---|--|
| Medical Foods and Amino Acid-based Formula <ul style="list-style-type: none"> <li>• Amino acid-based formula for eosinophilic gastrointestinal disorder</li> <li>• Medical foods for inherited metabolic disorders</li> </ul>   | 25% coinsurance<br>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 <ul style="list-style-type: none"> <li>• Combined total of physical, occupational, speech, cardiac and pulmonary therapy; and</li> <li>• Provided in an Outpatient Facility or home health setting</li> </ul> | 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 |
|---|---------|
| <b>Eye exam:</b> One per Calendar Year. Includes dilation, if Medically Necessary           | \$0     |
| Includes codes 92002/92004 New patient exams<br>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   |
|---|---|
| <b>You may choose either prescription glasses or contacts once per Calendar Year.</b>   |   |
| <p><b>Lenses:</b> One pair per Calendar Year.<br/>           Single Vision: V2100-2199<br/>           Conventional (Lined): V2200-2299<br/>           Bifocal: V2300-2399<br/>           Conventional (Lined) Trifocal: V2121, V2221,<br/>           Lenticular: V2321</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>Lenses include choice of glass or plastic lenses.</li> <li>All lenses include scratch resistant coating with no additional copayment.</li> <li>Fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses are not a covered benefit.</li> <li>Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions <math>\geq</math> +/- 6.00 diopters.</li> </ul> | \$0   |
| <p><b>Frame:</b> One per Calendar Year: V2020<br/>           Collection Frame<br/>           Non-collection frame</p>   | \$0<br>50% Coinsurance on expenses in excess of \$150   |
| <p><b>Contact Lenses:</b><br/>           Covered once per Calendar Year in lieu of eyeglasses.<br/>           V-2500-V2599</p>  | 50% Coinsurance on expenses in excess of \$150 (may be applied toward the cost of evaluation, materials, fitting and follow-up care)                    |
| <p><b>Medically Necessary Contact Lenses:</b><br/>           V2500-V2599</p>  | 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):<br>Generic - Tier 1<br><br>Preferred Brand - Tier 2<br><br>Non-preferred Brand - Tier 3<br><br>Specialty - Tier 4<br><br>Oncology - Tier 5<br><br>ACA Preventive - Tier 6   | \$10 Copay<br><br>\$45 Copay after deductible<br><br>50% Coinsurance after deductible<br><br>50% Coinsurance after deductible<br><br>20% Coinsurance after deductible<br><br>\$0 |
| Mail Order Pharmacy (up to a 90-day supply):<br>Generic -Tier 1<br><br>Preferred Brand - Tier 2<br><br>Non-preferred Brand - Tier 3<br><br>ACA Preventive - Tier 6   | \$25.00 Copay<br><br>\$112.50 Copay after deductible<br><br>50% Coinsurance after deductible<br><br>\$0  |
| <p>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.</p> |  |



**Live Healthy!  
Choose Health Choice!**

**MEMBER SERVICES**

1-855-452-4242

Monday-Friday, 6 a.m. - 6 p.m.

[www.healthchoiceessential.com](http://www.healthchoiceessential.com)

