America's Choice

2023 PRODUCT INFORMATION

	$3,500/$7,000 HSA
MAXIMUM ANNUAL BENEFIT AMOUNT	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)	$3,500
PER COVERED PERSON (Non-Contracted Physician)	$7,000
PER FAMILY UNIT (Contracted Physician)	$7,000
PER FAMILY UNIT (Non-Contracted Physician)	$14,000
CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	$7,350/$14,700
NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	$20,000/$40,000
COPAYMENTS	
Primary Care Physician Office Visits Family and General Practitioner, and Internist	20% After Deductible
Specialist office visits	20% After Deductible
Physical & Occupational Therapy	20% After Deductible
Speech Therapy	20% After Deductible
Cardiac Rehabilitation	20% After Deductible
Outpatient Mental Health/Substance Abuse	20% After Deductible
Prenatal/Postnatal Office Visits	20% After Deductible
Spinal Manipulation Chiropractic	20% After Deductible
Routine Vision Exam (One per year)	20% After Deductible
Urgent Care	20% After Deductible
TELEMEDICINE-General Medicine	20% After Deductible
TELEMEDICINE-Behavioral Health	20% After Deductible
TELEMEDICINE-Dermatology	20% After Deductible

PREVENTIVE SERVICES	
ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE
ADULT IMMUNIZATIONS: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria	100% OF ALLOWABLE
MAMMOGRAM	100% OF ALLOWABLE
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE
ROUTINE COLONOSCOPY	100% OF ALLOWABLE
WELL CHILD CARE/NEWBORN CARE	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)	80%, 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)	80%, 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)	80%, 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)	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*

OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY	
DIAGNOSTIC TESTING LAB, X-RAY	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
COMPLEX DIAGNOSTIC SERVICES CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SURGICAL SERVICES Procedures & Anesthesia	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
EMERGENCY / URGENT CARE	
URGENT CARE IN AN URGENT CARE FACILITY	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
INPATIENT HOSPITAL SERVICES	
ROOM AND BOARD Paid at the facility's semi-private room rate	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
INTENSIVE CARE UNIT Paid at the facility's semi-private room rate	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
MATERNITY SERVICES:	
ROOM AND BOARD Limited to semi-private room rate Dependent daughter pregnancy is not covered	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*

THERAPIES	
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
SPEECH THERAPY Limited to 20 visits per benefit period	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	80%, AFTER DEDUCTIBLE *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	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
OUTPATIENT MENTAL HEALTHCARE SERVICES	80% 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	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*

OTHER SERVICES	
HOME HEALTH CARE 60 visits per benefit period	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
HOSPICE CARE Residential / Facility	80% 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	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
DURABLE MEDICAL EQUIPMENT (DME): Limited to 12-month rental or purchase price, whichever is less	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
PROSTHETICS AND ORTHOTIC DEVICES: Max amount of $6,500 per member/per plan year	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
RX BENEFIT HIGHLIGHTS	
RX COMPANY	**Medalist RX**
PHONE#	855-633-2579
WEBSITE	www.medalistrx.com

RX COPAYMENTS	
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	20% AFTER DEDUCTIBLE
	20% AFTER DEDUCTIBLE
	20% AFTER DEDUCTIBLE
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	20% AFTER DEDUCTIBLE
	20% AFTER DEDUCTIBLE
	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.	