



## 2024 PRODUCT INFORMATION: \$500/\$1,000 TITANIUM

Rates effective as of June 1, 2023

<b>MAXIMUM ANNUAL BENEFIT AMOUNT</b>	UNLIMITED
<b>PER COVERED PERSON</b> (Contracted Physician)	\$500
<b>PER COVERED PERSON</b> (Non-Contracted Physician)	\$1,000
<b>PER FAMILY UNIT</b> (Contracted Physician)	\$1,000
<b>PER FAMILY UNIT</b> (Non-Contracted Physician)	\$2,000
<b>CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family)</b> Includes Deductible, Coinsurance & Copayments	\$7,350/\$14,700
<b>NON-CONTRACTED PHYSICIAN MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Individual/Family)</b> Includes Deductible, Coinsurance & Copayments	\$20,000/\$40,000
<b>COPAYMENTS</b>	
<b>Primary Care Physician Office Visits</b> Family and General Practitioner, and Internist	\$25 Copay
<b>Specialist office visits</b>	\$40 Copay
<b>Physical &amp; Occupational Therapy</b>	\$40 Copay
<b>Speech Therapy</b>	\$40 Copay
<b>Cardiac Rehabilitation</b>	\$40 Copay
<b>Outpatient Mental Health/Substance Abuse</b>	\$25 Copay
<b>Prenatal/Postnatal Office Visits</b>	\$25 Copay
<b>Spinal Manipulation Chiropractic</b>	\$40 Copay
<b>Routine Vision Exam (One per year)</b>	\$40 Copay
<b>Urgent Care</b>	\$60 Copay
<b>TELEMEDICINE-Primary Care</b>	\$0 Copay
<b>TELEMEDICINE-Urgent Care</b>	\$0 Copay
<b>TELEMEDICINE-Mental Health Therapy</b>	\$0 Copay

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### PREVENTIVE SERVICES - [Click Here for a complete list.](#)

**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)

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)

60%, 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

**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)

60%, AFTER Non-Certified Providers DEDUCTIBLE,  
Subject to Plan Allowable

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### 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 &amp; Nuclear Medicine

80% AFTER DEDUCTIBLE,

Subject to Plan Allowable

**SURGICAL SERVICES**

Procedures &amp; Anesthesia

80% AFTER DEDUCTIBLE,

Subject to Plan Allowable

### EMERGENCY / URGENT CARE

**URGENT CARE IN AN URGENT CARE FACILITY**

100% AFTER COPAY,

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

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<b>THERAPIES</b>	
<b>PHYSICAL &amp; OCCUPATIONAL THERAPIES</b> Limited to 20 visits combined per benefit period	100% AFTER COPAY, Subject to Plan Allowable
<b>SPEECH THERAPY</b> Limited to 20 visits per benefit period	100% AFTER COPAY, Subject to Plan Allowable
<b>CARDIAC REHABILITATION THERAPY</b> Limited to 36 visits per therapy, per benefit period	100% AFTER COPAY, Subject to Plan Allowable
<b>CHIROPRACTIC SERVICES/SPINAL MANIPULATION</b> Limited to 20 visits per benefit period	100% AFTER COPAY, Subject to Plan Allowable
<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	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>OUTPATIENT MENTAL HEALTHCARE SERVICES</b>	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT)</b>	
<b>SUBSTANCE ABUSE REHABILITATION-INPATIENT</b> Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>SUBSTANCE ABUSE REHABILITATION-OUTPATIENT</b>	80% AFTER DEDUCTIBLE, Subject to Plan Allowable

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<b>OTHER SERVICES</b>	
<b>HOME HEALTH CARE</b> 60 visits per benefit period	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>HOSPICE CARE</b> Residential / Facility	80% AFTER DEDUCTIBLE, 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	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>DURABLE MEDICAL EQUIPMENT (DME):</b> Limited to 12-month rental or purchase price, whichever is less	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>PROSTHETICS AND ORTHOTIC DEVICES:</b> Max amount of \$6,500 per member/per plan year	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>ALL OTHER COVERED CHARGES</b>	80% AFTER DEDUCTIBLE, Subject to Plan Allowable
<b>RX BENEFIT HIGHLIGHTS</b>	
<b>Rx Company</b>	<b>Medalist Rx</b>
<b>Phone</b>	855-633-2579
<b>Website</b>	<a href="https://www.MedalistRx.com">MedalistRx.com</a>
<b>Formulary</b>	<a href="#">Medalist Formulary</a>



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RX COPAYMENTS	
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	GENERIC-\$10 COPAY
	BRAND NAME -\$45 COPAY
	NON-PREFERRED BRAND- \$85 COPAY
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-\$30 COPAY
	BRAND NAME -\$90 COPAY
	NON-PREFERRED BRAND- \$150 COPAY
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.

**ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE PLAN ALLOWABLE.**

### PREMIUMS BY AGE BAND

	18-29 Years	30-44 Years	45-54 Years	55-64 Years
Employee	\$822.56	\$849.46	\$883.02	\$984.23
Employee + Spouse	\$1,505.10	\$1,558.90	\$1,626.03	\$1,828.43
Employee + Child(ren)	\$1,370.60	\$1,419.02	\$1,479.43	\$1,661.58
Family	\$2,192.67	\$2,273.37	\$2,374.05	\$2,677.64