



2024 PRODUCT INFORMATION: \$5000/\$10,000 BRONZE

Rates effective as of June 1, 2023

MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED
PER COVERED PERSON (Contracted Physician)	\$5,000
PER COVERED PERSON (Non-Contracted Physician)	\$10,000
PER FAMILY UNIT (Contracted Physician)	\$10,000
PER FAMILY UNIT (Non-Contracted Physician)	\$20,000
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	\$25 Copay
Specialist office visits	\$40 Copay
Physical & Occupational Therapy	\$40 Copay
Speech Therapy	\$40 Copay
Cardiac Rehabilitation	\$40 Copay
Outpatient Mental Health/Substance Abuse	\$25 Copay
Prenatal/Postnatal Office Visits	\$25 Copay
Spinal Manipulation Chiropractic	\$40 Copay
Routine Vision Exam (One per year)	\$40 Copay
Urgent Care	\$60 Copay
TELEMEDICINE-Primary Care	\$0 Copay
TELEMEDICINE-Urgent Care	\$0 Copay
TELEMEDICINE-Mental Health Therapy	\$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 & 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	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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THERAPIES	
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	100% AFTER COPAY, Subject to Plan Allowable
SPEECH THERAPY Limited to 20 visits per benefit period	100% AFTER COPAY, Subject to Plan Allowable
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	100% AFTER COPAY, Subject to Plan Allowable
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	100% AFTER COPAY, 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)	
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

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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	MedalistRx.com
Formulary	Medalist Formulary



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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	\$565.74	\$582.37	\$603.12	\$645.72
Employee + Spouse	\$991.47	\$1,024.73	\$1,066.22	\$1,151.43
Employee + Child(ren)	\$908.33	\$938.26	\$975.60	\$1,052.28
Family	\$1,422.21	\$1,472.10	\$1,534.34	\$1,662.14