

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

Rates effective as of July 1, 2024

|                                                                                                                                        |                   |
|----------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| 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)<br>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<br>Family and General Practitioner, and Internist                                                 | \$25 Copay        |
| Specialist office visits                                                                                                               | \$45 Copay        |
| Physical & Occupational Therapy                                                                                                        | \$45 Copay        |
| Speech Therapy                                                                                                                         | \$45 Copay        |
| Cardiac Rehabilitation                                                                                                                 | \$45 Copay        |
| Outpatient Mental Health/Substance Abuse                                                                                               | \$25 Copay        |
| Prenatal/Postnatal Office Visits                                                                                                       | \$25 Copay        |
| Spinal Manipulation Chiropractic                                                                                                       | \$45 Copay        |
| Routine Vision Exam (One per year)                                                                                                     | \$45 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                                   |                                                    |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| <b>DIAGNOSTIC TESTING</b><br>LAB, X-RAY                                                                   | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>COMPLEX DIAGNOSTIC SERVICES</b><br>CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine                   | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>SURGICAL SERVICES</b><br>Procedures & Anesthesia                                                       | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| EMERGENCY / URGENT CARE                                                                                   |                                                    |
| <b>URGENT CARE IN AN URGENT CARE FACILITY</b>                                                             | 100% AFTER COPAY,<br>Subject to Plan Allowable     |
| <b>EMERGENCY ROOM SERVICES</b>                                                                            | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>EMERGENCY AMBULANCE SERVICES</b><br>Ground / Air Ambulance                                             | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| INPATIENT HOSPITAL SERVICES                                                                               |                                                    |
| <b>ROOM AND BOARD</b><br>Paid at the facility's semi-private room rate                                    | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>INTENSIVE CARE UNIT</b><br>Paid at the facility's semi-private room rate                               | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| MATERNITY SERVICES:                                                                                       |                                                    |
| <b>ROOM AND BOARD</b><br>Limited to semi-private room rate<br>Dependent daughter pregnancy is not covered | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |

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| THERAPIES                                                                                                            |                                                    |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| <b>PHYSICAL &amp; OCCUPATIONAL THERAPIES</b><br>Limited to 20 visits combined per benefit period                     | 100% AFTER COPAY,<br>Subject to Plan Allowable     |
| <b>SPEECH THERAPY</b><br>Limited to 20 visits per benefit period                                                     | 100% AFTER COPAY,<br>Subject to Plan Allowable     |
| <b>CARDIAC REHABILITATION THERAPY</b><br>Limited to 36 visits per therapy, per benefit period                        | 100% AFTER COPAY,<br>Subject to Plan Allowable     |
| <b>CHIROPRACTIC SERVICES/SPINAL MANIPULATION</b><br>Limited to 20 visits per benefit period                          | 100% AFTER COPAY,<br>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><br>Paid at the facility's semi-private room rate | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>OUTPATIENT MENTAL HEALTHCARE SERVICES</b>                                                                         | 80% AFTER DEDUCTIBLE,<br>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><br>Paid at the facility's semi-private room rate                     | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |
| <b>SUBSTANCE ABUSE REHABILITATION-OUTPATIENT</b>                                                                     | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable |

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| OTHER SERVICES                                                                                                             |                                                         |
|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| <b>HOME HEALTH CARE</b><br>60 visits per benefit period                                                                    | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| <b>HOSPICE CARE</b><br>Residential / Facility                                                                              | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| <b>SKILLED NURSING CARE</b><br>Paid at facility's semi-private room rate and limited to 60 days per benefit period maximum | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| <b>DURABLE MEDICAL EQUIPMENT (DME):</b><br>Limited to 12-month rental or purchase price, whichever is less                 | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| <b>PROSTHETICS AND ORTHOTIC DEVICES:</b><br>Max amount of \$6,500 per member/per plan year                                 | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| <b>ALL OTHER COVERED CHARGES</b>                                                                                           | 80% AFTER DEDUCTIBLE,<br>Subject to Plan Allowable      |
| RX BENEFIT HIGHLIGHTS                                                                                                      |                                                         |
| <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<br>(30 DAY SUPPLY)               | GENERIC-\$10 COPAY                                                                                                                                                                                                                            |
|                                                             | BRAND NAME -\$45 COPAY                                                                                                                                                                                                                        |
|                                                             | NON-PREFERRED BRAND- \$85 COPAY                                                                                                                                                                                                               |
| MAIL ORDER OR RETAIL PHARMACY COPAYMENTS<br>(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              | \$582.63    | \$600.00    | \$626.67    | \$666.20    |
| Employee + Spouse     | \$1,027.07  | \$1,061.82  | \$1,110.16  | \$1,194.22  |
| Employee + Child(ren) | \$940.18    | \$971.46    | \$1,015.46  | \$1,090.61  |
| Family                | \$1,476.51  | \$1,528.65  | \$1,598.67  | \$1,727.24  |