America's Choice

2024 PRODUCT INFORMATION: $2,500/$5,000 GOLD

Rates effective as of July 1, 2024

MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED
PER COVERED PERSON (Contracted Physician)	$2,500
PER COVERED PERSON (Non-Contracted Physician)	$5,000
PER FAMILY UNIT (Contracted Physician)	$5,000
PER FAMILY UNIT (Non-Contracted Physician)	$10,000
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	$689.25	$710.89	$742.88	$819.31
Employee + Spouse	$1,240.31	$1,283.60	$1,342.58	$1,500.43
Employee + Child(ren)	$1,132.10	$1,171.06	$1,224.64	$1,366.20
Family	$1,796.39	$1,861.32	$1,947.30	$2,186.56