Am	eri	ca's
*	Ch	oice

America's * Choice	EE ES EC	\$984.23 \$1,828.43 \$1,661.58 \$2,677.64	\$917.49 \$1,694.95 \$1,541.46 \$2,477.43	\$847.71 \$1,555.41 \$1,415.87 \$2,268.12	\$792.23 \$1,444.45 \$1,316.00 \$2,101.68	\$740.86 \$1,341.70 \$1,223.52 \$1,947.54	\$690.77 \$1,241.54 \$1,133.38 \$1,797.31	\$620.21 \$1,100.40 \$1,006.37 \$1,585.61	\$645.72 \$1,151.43 \$1,052.28 \$1,662.14	\$601.40 \$1,062.79 \$972.51 \$1,529.19	\$546.44 \$952.86 \$873.58 \$1,364.30
*America's Choice Physician & Ancillary RBP Plan Structure 2023 PRODUCT INFORMATION		\$500/\$1,000 TITANIUM	\$1,000/\$2,000 DIAMOND	\$1,500/\$3,000 PLATINUM	\$2,500/\$5,000 GOLD	\$2,500/\$5,000 HSA	\$3,500/\$7,000 SILVER	\$3,500/\$7,000 HSA	\$5,000/\$10,000 BRONZE	\$5,000/\$10,000 HSA	\$7,350/\$14,700 COPPER
MAXIMUM ANNUAL BENEFIT AMOUNT		UNLIMITED	UNLIMITED	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)	\$500	\$1,000	\$1,500	\$2,500	\$2,500	\$3,500	\$3,500	\$5,000	\$5,000	\$7,350
PER COVERED PERSON (Non-Contracted Physician)	\$1,000	\$2,000	\$3,000	\$5,000	\$5,000	\$7,000	\$7,000	\$10,000	\$10,000	\$14,700
PER FAMILY UNIT (Contracted Physician)	\$1,000	\$2,000	\$3,000	\$5,000	\$5,000	\$7,000	\$7,000	\$10,000	\$10,000	\$14,700
PER FAMILY UNIT (Non- Contracted Physician)	\$2,000	\$4,000	\$6,000	\$10,000	\$10,000	\$14,000	\$14,000	\$20,000	\$20,000	\$29,400
CONTRACTED PHYSICIAN NETWORK MAXIMUM OUT-OF- POCKET AMOUNT, PER PLAN YEAR (Individual/Family) Includes Deductible, Coinsurance & Copayments	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$7,350/\$14,700	\$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	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000	\$20,000/\$40,000
COPAYMENTS										
Primary Care Physician Office Visits (Family and General Practitioner, and Internist)	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay
Specialist Office Visits	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Physical & Occupational Therapy	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Speech Therapy	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Cardiac Rehabilitation	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Outpatient Mental Health/Substance Abuse	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay
Prenatal/Postnatal Office Visits	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay
Spinal Manipulation Chiropractic	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Routine Vision Exam (One per year)	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
Urgent Care	\$60 Copay	\$60 Copay	\$60 Copay	\$60 Copay	20% After Deductible	\$60 Copay	20% After Deductible	\$60 Copay	20% After Deductible	\$60 Copay
TELEMEDICINE-General Medicine	\$5 Copay	\$5 Copay	\$5 Copay	\$5 Copay	20% After Deductible	\$5 Copay	20% After Deductible	\$5 Copay	20% After Deductible	\$5 Copay
TELEMEDICINE-Behavioral Health	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay	20% After Deductible	\$25 Copay
TELEMEDICINE-Dermatology	\$45 Copay	\$45 Copay	\$45 Copay	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay	20% After Deductible	\$45 Copay
PREVENTIVE SERVICES										
ANNUAL ADULT PHYSICAL	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				
ADULT IMMUNIZATIONS: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				
MAMMOGRAM	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				
GYNECOLOGICAL SERVICES	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				
ROUTINE COLONOSCOPY	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE				

*America's Choice Physician & Ancillary RBP Plan Structure	\$500/\$1,000 TITANIUM	\$1,000/\$2,000 DIAMOND	\$1,500/\$3,000 PLATINUM	\$2,500/\$5,000 GOLD	\$2,500/\$5,000 HSA	\$3,500/\$7,000 SILVER	\$3,500/\$7,000 HSA	\$5,000/\$10,000 BRONZE	\$5,000/\$10,000 HSA	\$7,350/\$14,700 COPPER
2023 PRODUCT INFORMATION										
PHYSICIAN SERVICES: PERFORMED AND BILLED IN OFFICE	<u> </u>	<u> </u>		<u> </u>		<u> </u>	<u> </u>		<u> </u>	
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/PET7 SPECT/MRA) (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	60%, AFTER Non-Certified	60%, AFTER Non-Certified	60%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	100%, 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,	100%, AFTER COPAY,	100%, AFTER COPAY,	100%, AFTER COPAY,	80%, AFTER COPAY,	100%, AFTER COPAY,	80%, AFTER COPAY,	100%, AFTER COPAY,	80%, AFTER COPAY,	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	60%, AFTER Non-Certified	60%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	60%, AFTER Non-Certified	80%, AFTER Non-Certified	100%, AFTER Non-Certified
	Providers DEDUCTIBLE,									
	Subject to Plan Allowable									
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN	OUTPATIENT FACILITY									
DIAGNOSTIC TESTING	80%, AFTER DEDUCTIBLE,	100%, AFTER DEDUCTIBLE,								
LAB, X-RAY	Subject to Plan Allowable									
COMPLEX DIAGNOSTIC SERVICES CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine	80%, AFTER DEDUCTIBLE,	100%, AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
SURGICAL SERVICES Procedures & Anesthesia	80%, AFTER DEDUCTIBLE,	100%, AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
EMERGENCY / URGENT CARE										
URGENT CARE IN AN URGENT CARE FACILITY	100%, AFTER COPAY, Subject	100%, AFTER COPAY,								
	to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE	100%, AFTER DEDUCTIBLE								
	Subject to Plan Allowable									
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	80%, AFTER DEDUCTIBLE	100%, AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
INPATIENT HOSPITAL SERVICES										
ROOM AND BOARD Paid at the Facility's Semi-Private room rate	80%, AFTER DEDUCTIBLE	100%, AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
INTENSIVE CARE UNIT Paid at the Facility's Semi-Private room rate	80%, AFTER DEDUCTIBLE	100%, 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	100%, AFTER DEDUCTIBLE, Subject to Plan Allowable								

W A manipala Chaina										
*America's Choice Physician & Ancillary RBP Plan Structure	\$500/\$1,000 TITANIUM	\$1,000/\$2,000 DIAMOND	\$1,500/\$3,000 PLATINUM	\$2,500/\$5,000 GOLD	\$2,500/\$5,000 HSA	\$3,500/\$7,000 SILVER	\$3,500/\$7,000 HSA	\$5,000/\$10,000 BRONZE	\$5,000/\$10,000 HSA	\$7,350/\$14,700 COPPER
2023 PRODUCT INFORMATION THERAPIES										
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
SPEECH THERAPY Limited to 20 visits per benefit period	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,	80%, AFTER DEDUCTIBLE,	100% AFTER COPAYMENT,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
MENTAL HEALTH CARE SERVICES: SUBJECT TO GROUP SIZE AI	ND REGULATORY REQUIREME	NTS (SEE PLAN DOCUMENT)								
INPATIENT/PARTIAL HOSPITALIZATION MENTAL HEALTHCARE SERVICES Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
OUTPATIENT MENTAL HEALTHCARE SERVICES	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND	REGULATORY REQUIREMENTS	S (SEE PLAN DOCUMENT FOR D	PETAILS)							
SUBSTANCE ABUSE REHABILITATION-INPATIENT Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
OTHER SERVICES										
HOME HEALTH CARE	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
60 visits per benefit period	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
HOSPICE CARE	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
Residential / Facility	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	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,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
DURABLE MEDICAL EQUIPMENT (DME): Limited to 12 month rental or purchase price, whichever is less	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
PROSTHETICS AND ORTHOTIC DEVICES Max amount of \$6,500 per member/per plan year	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable
ALL OTHER COVERED CHARGES	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,
	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable	Subject to Plan Allowable

*America's Choice Physician & Ancillary RBP Plan Structure 2023 PRODUCT INFORMATION RX BENEFIT HIGHLIGHTS	\$500/\$1,000 TITANIUM	\$1,000/\$2,000 DIAMOND	\$1,500/\$3,000 PLATINUM	\$2,500/\$5,000 GOLD	\$2,500/\$5,000 HSA	\$3,500/\$7,000 SILVER	\$3,500/\$7,000 HSA	\$5,000/\$10,000 BRONZE	\$5,000/\$10,000 HSA	\$7,350/\$14,700 COPPER		
RX COMPANY	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX	APS Formulary		
PHONE#	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579	1-800-974-7036		
WEBSITE	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	americaspharmacysource.com		
RX COPAYMENTS												
	GENERIC-\$10 COPAYMENT	GENERIC-\$10 COPAYMENT	GENERIC-\$10 COPAYMENT	GENERIC-\$10 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-\$10 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-\$10 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary		
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	BRAND NAME FORMULARY - \$45 COPAYMENT	BRAND NAME FORMULARY - \$45 COPAYMENT	BRAND NAME FORMULARY - \$45 COPAYMENT	BRAND NAME FORMULARY - \$45 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME FORMULARY - \$45 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME FORMULARY - \$45 COPAYMENT	20% AFTER DEDUCTIBLE			
	NON-PREFERRED BRAND - \$85 COPAYMENT	NON-PREFERRED BRAND - \$85 COPAYMENT	NON-PREFERRED BRAND - \$85 COPAYMENT	NON-PREFERRED BRAND - \$85 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - \$100 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - \$100 COPAYMENT	20% AFTER DEDUCTIBLE			
	GENERIC-\$30 COPAYMENT	GENERIC-\$30 COPAYMENT	GENERIC-\$30 COPAYMENT	GENERIC-\$30 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-\$30 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-\$30 COPAYMENT	20% AFTER DEDUCTIBLE			
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	BRAND NAME -\$90 COPAYMENT	BRAND NAME -\$90 COPAYMENT	BRAND NAME -\$90 COPAYMENT	BRAND NAME -\$90 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME -\$90 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME -\$90 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary		
	NON-PREFERRED BRAND - \$150 COPAYMENT	NON-PREFERRED BRAND - \$150 COPAYMENT	NON-PREFERRED BRAND - \$150 COPAYMENT	NON-PREFERRED BRAND - \$150 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - \$150 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - \$150 COPAYMENT	20% AFTER DEDUCTIBLE			
SPECIALTY MEDS	**SPECIALITY MEDICATIONS AF	CIALITY 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.