America's Choice

2024 PRODUCT INFORMATION: $5000/$10,000 HSA

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) Includes Deductible, Coinsurance & Copayments	$6,550/$13,100
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	20% After Deductible
Specialist office visits	20% After Deductible
Physical & Occupational Therapy	20% After Deductible
Speech Therapy	20% After Deductible
Cardiac Rehabilitation	20% After Deductible
Outpatient Mental Health/Substance Abuse	20% After Deductible
Prenatal/Postnatal Office Visits	20% After Deductible
Spinal Manipulation Chiropractic	20% After Deductible
Routine Vision Exam (One per year)	20% After Deductible
Urgent Care	20% After Deductible
TELEMEDICINE-Primary Care	Included **
TELEMEDICINE-Urgent Care	Included **
TELEMEDICINE-Mental Health Therapy	Included **

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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)	80%, AFTER DEDUCTIBLE, 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)	80%, 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)	80%, AFTER DEDUCTIBLE, 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)	80%, 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	80%, AFTER DEDUCTIBLE 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	80%, AFTER DEDUCTIBLE, Subject to Plan Allowable
SPEECH THERAPY Limited to 20 visits per benefit period	80%, AFTER DEDUCTIBLE, Subject to Plan Allowable
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	80%, AFTER DEDUCTIBLE, Subject to Plan Allowable
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	80%, AFTER DEDUCTIBLE, 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 COPAYMENT AFTER DEDUCTIBLE
	BRAND NAME FORMULARY -$45 COPAYMENT AFTER DEDUCTIBLE
	NON-PREFERRED BRAND - $85 COPAYMENT AFTER DEDUCTIBLE
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-$30 COPAYMENT AFTER DEDUCTIBLE
	BRAND NAME -$90 COPAYMENT AFTER DEDUCTIBLE
	NON-PREFERRED BRAND - $150 COPAYMENT AFTER DEDUCTIBLE
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.

** Telemedicine Disclaimer - Inclusion of this benefit is subject to change according to the Consolidated Appropriations Act, 2023

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	$543.78	$559.61	$584.33	$619.89
Employee + Spouse	$949.38	$981.03	$1,025.50	$1,101.59
Employee + Child(ren)	$870.26	$898.75	$939.27	$1,007.25
Family	$1,359.99	$1,407.46	$1,471.67	$1,588.30