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
MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	UNLIMITED	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
PER COVERED PERSON (Non-Contracted Physician)	$1,000	$2,000	$3,000	$5,000	$5,000
PER FAMILY UNIT (Contracted Physician)	$1,000	$2,000	$3,000	$5,000	$5,000
PER FAMILY UNIT (Non- Contracted Physician)	$2,000	$4,000	$6,000	$10,000	$10,000
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
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
COPAYMENTS					
Primary Care Physician Office Visits (Family and General Practitioner, and Internist)	$25 Copay	$25 Copay	$25 Copay	$25 Copay	20% After Deductible
Specialist Office Visits	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible
Physical & Occupational Therapy	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible
Speech Therapy	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible
Cardiac Rehabilitation	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible
Outpatient Mental Health/Substance Abuse	$25 Copay	$25 Copay	$25 Copay	$25 Copay	20% After Deductible
Prenatal/Postnatal Office Visits	$25 Copay	$25 Copay	$25 Copay	$25 Copay	20% After Deductible
Spinal Manipulation Chiropractic	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible

Routine Vision Exam (One per year)	$40 Copay	$40 Copay	$40 Copay	$40 Copay	20% After Deductible
Urgent Care	$60 Copay	$60 Copay	$60 Copay	$60 Copay	20% After Deductible
TELEMEDICINE-General Medicine	$5 Copay	$5 Copay	$5 Copay	$5 Copay	20% After Deductible
TELEMEDICINE-Behavioral Health	$25 Copay	$25 Copay	$25 Copay	$25 Copay	20% After Deductible
TELEMEDICINE-Dermatology	$45 Copay	$45 Copay	$45 Copay	$45 Copay	20% After Deductible
PREVENTIVE SERVICES					
ANNUAL ADULT PHYSICAL	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
MAMMOGRAM	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
ROUTINE COLONOSCOPY	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
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
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*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	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*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	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)	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	80%, 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*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY					
DIAGNOSTIC TESTING LAB, X-RAY	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	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*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SURGICAL SERVICES Procedures & Anesthesia	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
EMERGENCY / URGENT CARE					
URGENT CARE IN AN URGENT CARE FACILITY	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
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
MATERNITY SERVICES:					
ROOM AND BOARD - Limited to semi-private room rate. Dependent daughter pregnancy is not covered.	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
THERAPIES					
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SPEECH THERAPY Limited to 20 visits per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*

OUTPATIENT MENTAL HEALTHCARE SERVICES	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT FOR DETAILS)					
SUBSTANCE ABUSE REHABILITATION-INPATIENT Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
OTHER SERVICES					
HOME HEALTH CARE 60 visits per benefit period	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
HOSPICE CARE Residential / Facility	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*

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
RX BENEFIT HIGHLIGHTS					
RX COMPANY	Medalist RX	Medalist RX	Medalist RX	Medalist RX	Medalist RX
PHONE#	855-633-2579	855-633-2579	855-633-2579	855-633-2579	855-633-2579
WEBSITE	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/	https://www.medalistrx.com/
RX COPAYMENTS					
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT	GENERIC-$10 COPAYMENT	20% AFTER DEDUCTIBLE
	BRAND NAME FORMULARY - $45 COPAYMENT	BRAND NAME FORMULARY - $45 COPAYMENT	BRAND NAME FORMULARY - $45 COPAYMENT	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
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT	GENERIC-$30 COPAYMENT	20% AFTER DEDUCTIBLE
	BRAND NAME -$90 COPAYMENT	BRAND NAME -$90 COPAYMENT	BRAND NAME -$90 COPAYMENT	BRAND NAME -$90 COPAYMENT	20% AFTER DEDUCTIBLE
	NON-PREFERRED BRAND - $150 COPAYMENT	NON-PREFERRED BRAND - $150 COPAYMENT	NON-PREFERRED BRAND - $150 COPAYMENT	NON-PREFERRED BRAND - $150 COPAYMENT	20% 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.

Pricing By Age Band

	$500/$1,000 Titanium	$1,000/$2,000 diamond	$1,500/$3,000 Platinum	$2,500/$5,000 Gold	$2,500/$5,000 HSA
EE	$849.46	$793.51	$735.00	$688.49	$645.40
ES	$1,558.90	$1,446.99	$1,330.00	$1,236.96	$1,150.81
EC	$1,419.02	$1,318.30	$1,213.00	$1,129.26	$1,051.72
FAM	$2,273.37	$2,105.50	$1,930.00	$1,790.44	$1,661.21

EE	$883.02	$824.38	$763.07	$714.32	$669.18
ES	$1,626.03	$1,508.75	$1,386.13	$1,288.63	$1,198.34
EC	$1,479.43	$1,373.88	$1,263.52	$1,175.77	$1,094.51
FAM	$2,374.05	$2,198.12	$2,014.21	$1,867.96	$1,732.52

EE	$984.23	$917.49	$847.71	$792.23	$740.86
ES	$1,828.43	$1,694.95	$1,555.41	$1,444.45	$1,341.70
EC	$1,661.58	$1,541.46	$1,415.87	$1,316.00	$1,223.52

FAM	$2,677.64	$2,477.43	$2,268.12	$2,101.68	$1,947.54
Physician & Ancillary RBP Plan Structure 2023 PRODUCT information	$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	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)	$3,500	$3,500	$5,000	$5,000	$7,350
PER COVERED PERSON (Non-Contracted Physician)	$7,000	$7,000	$10,000	$10,000	$14,700
PER FAMILY UNIT (Contracted Physician)	$7,000	$7,000	$10,000	$10,000	$14,700
PER FAMILY UNIT (Non- Contracted Physician)	$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
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
COPAYMENTS					
Primary Care Physician Office Visits (Family and General Practitioner, and Internist)	$25 Copay	20% After Deductible	$25 Copay	20% After Deductible	$25 Copay
Specialist Office Visits	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Physical & Occupational Therapy	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Speech Therapy	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Cardiac Rehabilitation	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Outpatient Mental Health/Substance Abuse	$25 Copay	20% After Deductible	$25 Copay	20% After Deductible	$25 Copay
Prenatal/Postnatal Office Visits	$25 Copay	20% After Deductible	$25 Copay	20% After Deductible	$25 Copay
Spinal Manipulation Chiropractic	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Routine Vision Exam (One per year)	$45 Copay	20% After Deductible	$45 Copay	20% After Deductible	$45 Copay
Urgent Care	$60 Copay	20% After Deductible	$60 Copay	20% After Deductible	$60 Copay
TELEMEDICINE-General Medicine	$5 Copay	20% After Deductible	$5 Copay	20% After Deductible	$5 Copay
TELEMEDICINE-Behavioral Health	$25 Copay	20% After Deductible	$25 Copay	20% After Deductible	$25 Copay
TELEMEDICINE-Dermatology	$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
ADULT IMMUNIZATIONS: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria	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
GYNECOLOGICAL SERVICES	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
WELL CHILD CARE/NEWBORN CARE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE	100% OF ALLOWABLE
Physician & Ancillary PPO Plan Structure 2023 PRODUCT information	$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
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*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	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*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	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, *Subject to Plan Allowable*	80%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	80%, AFTER COPAY, *Subject to Plan Allowable*	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*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	60%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER Non-Certified Providers DEDUCTIBLE, *Subject to Plan Allowable*
OUTPATIENT SERVICES WHEN PERFORMED AND BILLED IN AN OUTPATIENT FACILITY					
DIAGNOSTIC TESTING LAB, X-RAY	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
COMPLEX DIAGNOSTIC SERVICES CT Scan, MRI, Ultra Sound, PET & Nuclear Medicine	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SURGICAL SERVICES Procedures & Anesthesia	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
EMERGENCY / URGENT CARE					
URGENT CARE IN AN URGENT CARE FACILITY	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*	100%, AFTER COPAY, *Subject to Plan Allowable*
EMERGENCY ROOM SERVICES	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE *Subject to Plan Allowable*

EMERGENCY AMBULANCE SERVICES Ground / Air Ambulance	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	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 *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, 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*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE *Subject to Plan Allowable*
Physician & Ancillary PPP Plan Structure 2023 PRODUCT information	$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
MATERNITY SERVICES:					
ROOM AND BOARD - Limited to semi-private room rate. Dependent daughter pregnancy is not covered.	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE *Subject to Plan Allowable*	100%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*
THERAPIES					
PHYSICAL & OCCUPATIONAL THERAPIES Limited to 20 visits combined per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
SPEECH THERAPY Limited to 20 visits per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
CARDIAC REHABILITATION THERAPY Limited to 36 visits per therapy, per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*
CHIROPRACTIC SERVICES/SPINAL MANIPULATION Limited to 20 visits per benefit period	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *Subject to Plan Allowable*	80%, AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER COPAYMENT, *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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
OUTPATIENT MENTAL HEALTHCARE SERVICES	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND REGULATORY REQUIREMENTS (SEE PLAN DOCUMENT FOR DETAILS)					
SUBSTANCE ABUSE REHABILITATION-INPATIENT Paid at the facility's semi-private room rate	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
OTHER SERVICES					

HOME HEALTH CARE 60 visits per benefit period	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
HOSPICE CARE Residential / Facility	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% 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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% 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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% 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*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
ALL OTHER COVERED CHARGES	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	80% AFTER DEDUCTIBLE, *Subject to Plan Allowable*	100% AFTER DEDUCTIBLE, *Subject to Plan Allowable*
Physician & Ancillary PPO Plan Structure 2023 PRODUCT information	$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 BENEFIT HIGHLIGHTS					
RX COMPANY	Medalist RX	Medalist RX	Medalist RX	Medalist RX	APS Formulary
PHONE#	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/	americaspharmacysource.com
RX COPAYMENTS					
RETAIL PHARMACY COPAYMENTS (30 DAY SUPPLY)	GENERIC-$10 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-$10 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary
	BRAND NAME FORMULARY - $45 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME FORMULARY - $45 COPAYMENT	20% AFTER DEDUCTIBLE	
	NON-PREFERRED BRAND - $100 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - $100 COPAYMENT	20% AFTER DEDUCTIBLE	
MAIL ORDER OR RETAIL PHARMACY COPAYMENTS (90 DAY SUPPLY)	GENERIC-$30 COPAYMENT	20% AFTER DEDUCTIBLE	GENERIC-$30 COPAYMENT	20% AFTER DEDUCTIBLE	APS Formulary
	BRAND NAME -$90 COPAYMENT	20% AFTER DEDUCTIBLE	BRAND NAME -$90 COPAYMENT	20% AFTER DEDUCTIBLE	
	NON-PREFERRED BRAND - $150 COPAYMENT	20% AFTER DEDUCTIBLE	NON-PREFERRED BRAND - $150 COPAYMENT	20% AFTER DEDUCTIBLE	
SPECIALTY MEDS					
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.					

Pricing By Age Band

		$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
AGES 18-44	EE	$621.67	$560.12	$582.37	$543.71	$495.77
	ES	$1,103.32	$980.23	$1,024.73	$947.42	$851.54
	EC	$1,008.99	$898.21	$938.26	$868.68	$782.39
	FAM	$1,589.99	$1,405.35	$1,472.10	$1,356.13	$1,212.32
AGES 45-55	EE	$644.30	$579.80	$603.12	$562.61	$512.37
	ES	$1,148.59	$1,019.59	$1,066.22	$985.20	$884.72
	EC	$1,049.73	$933.63	$975.60	$902.68	$812.25
	FAM	$1,657.89	$1,464.38	$1,534.34	$1,412.81	$1,262.09
AGES 56-62	EE	$690.77	$620.21	$645.72	$601.40	$546.44
	ES	$1,241.54	$1,100.40	$1,151.43	$1,062.79	$952.86
	EC	$1,133.38	$1,006.37	$1,052.28	$972.51	$873.58
	FAM	$1,797.31	$1,585.61	$1,662.14	$1,529.19	$1,364.30