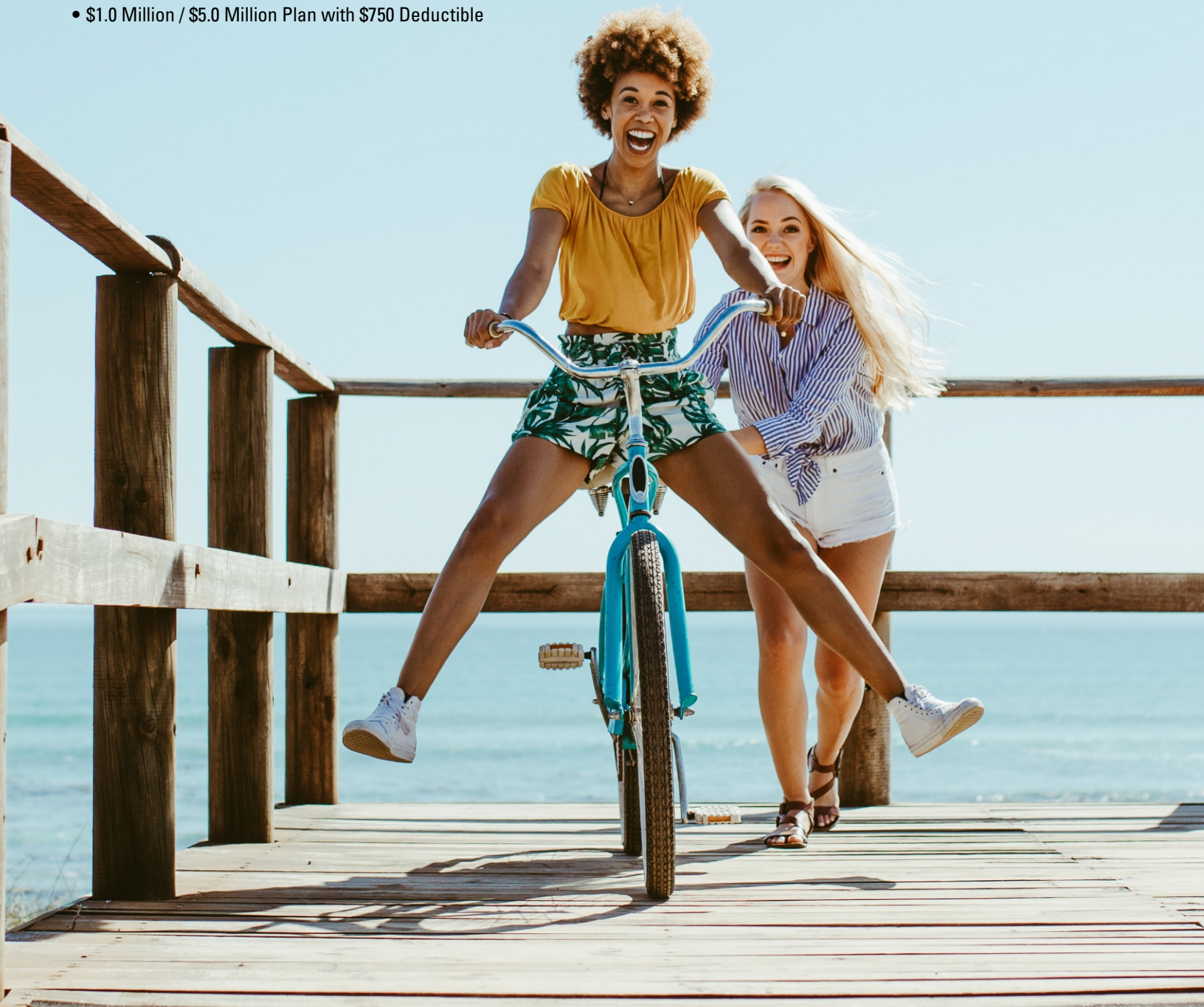
America's Choice

Coverage: 06/01/2024 - 05/31/2025

Plan Comparison: Summary of Benefits and Coverage

- $1.0 Million / $5.0 Million Plan with $250 Deductible
- $1.0 Million / $5.0 Million Plan with $500 Deductible
- $1.0 Million / $5.0 Million Plan with $750 Deductible



Summary of Benefits and Coverage: Plan Comparison

America's Choice

$1.0 Million / $5.0 Million Plans: $250 Deductible · $500 Deductible · $750 Deductible

Coverage: 06/01/24 - 05/31/25

PLAN	$1M/$5M - 250	$1M/$5M - 500	$1M/$5M - 750
Subject to plan allowable The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.detegohealth.com or call 1-866-815-6001. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov			
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)			
• Individual	$250	$500	$750
• Family Unit (Accumulated)	$500	$1,000	$1,500
Maximum Annual Benefit Amount			
• Yearly	$1,000,000	$1,000,000	$1,000,000
• Lifetime	$5,000,000	$5,000,000	$5,000,000

Copays Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Annual Lab / X-Ray Tests
- Annual Pap Smear / Mammogram
- Cancer Screenings
- Colonoscopies
- Diabetic Supply
- Immunizations
- Other Preventative Screenings
- Precision Rx (Prescriptions)
- Telemedicine (including Mental Health Services)
- Urgent Care and Office Visits
- Well Baby Care
- Wellness Visits

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's Dental Check-Up
- Children's Glasses
- Children's Eye Exam
- Dialysis
- Biofeedback
- Mental Health Services (except for Telemedicine)
- Substance Abuse Services
- Organ Transplant Services

Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.

Precertification

Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, 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.

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Coverage: 06/01/24 - 05/31/25

PLAN	$1M/$5M - 250	$1M/$5M - 500	$1M/$5M - 750
Covered Services - Illness or Injury			
Physician Office Services • Primary Care Physician Office Visit - 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits. • Specialist Physician Office Visit - 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits. • Urgent Care Visit - 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.	$50 Copay (after deductible)	$50 Copay (after deductible)	$50 Copay (after deductible)
Telemedicine (Unlimited for Telemedicine Platform. Virtual/Telemedicine Physician Office visits are included in the 10 Visit Maximum; subject to copay/deductible). • Virtual Primary Care (Including Dermatology) - 12 visit limit per benefit period. • Urgent Care - Unlimited • Mental Health - 4 visits limit per benefit period. • Telemedicine Pharmacy - See Your Telemedicine Formulary	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible
Emergency Services • Emergency Room Care - 2 visit limit per benefit period for Accident related visits. 2 visit limit per benefit period for Sickness related visits. • Emergency Medical Transportation - 2 visit per benefit period maximum. Combined for Ground and Air ambulance services.	$250 Copay (after deductible) $0 Copay, $0 Deductible	$250 Copay (after deductible) $0 Copay, $0 Deductible	$250 Copay (after deductible) $0 Copay, $0 Deductible
Outpatient Services • Outpatient Hospital/Ambulatory Surgical Center, All fees. - 3 surgeries per Plan Year.	$250 Copay (after deductible)	$250 Copay (after deductible)	$250 Copay (after deductible)
Inpatient Services • Inpatient Hospital Services, Facility / Physician fees. - Paid at facility's semi-private room rate. Non-ICU stays limited to 2 hospitalizations per benefit period. ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization. • Inpatient Hospital Surgical Services, All fees. - 2 surgeries per Plan Year.	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)	$1,000 Copay/Admission (after deductible) $1,000 Copay/Surgery (after deductible)
Testing • Diagnostic Test (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging) - 3 per Benefit Plan Year. • Imaging (CT/PET Scans, MRIs, MRAs) - 3 per Benefit Plan Year.	$50 Copay (after deductible) $250 Copay (after deductible)	$50 Copay (after deductible) $250 Copay (after deductible)	$50 Copay (after deductible) $250 Copay (after deductible)

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Preventive Care			
Preventive Care / Screening / Immunization (You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Services are limited to those covered by the Affordable Care Act. All services must be conducted in office, hospital services are not covered.)	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible	$0 Copay, $0 Deductible
Mental Health, Behavioral Health and/or Substance Use Disorder Services			
Inpatient Services (Includes Facility and Professional Fees Included in the inpatient hospitalization limit).	$250 Copay/Admission (after deductible)	$250 Copay/Admission (after deductible)	$250 Copay/Admission (after deductible)
Outpatient Services			
• Outpatient Services	Not Covered	Not Covered	Not Covered
Other Covered Services - Illness or Injury			
Pregnancy, Maternity Global Maternity Services, All fees. (Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc. Capped at $15,000 Per Plan Year. Excludes Genetic testing unless medically necessary).			
• Routine Vaginal Delivery	$250 Copay/Admission (after deductible)	$250 Copay/Admission (after deductible)	$250 Copay/Admission (after deductible)
• Routine C-Section Delivery	$500 Copay/Admission (after deductible)	$500 Copay/Admission (after deductible)	$500 Copay/Admission (after deductible)
• All Other Maternity Services	100% Covered	100% Covered	100% Covered
Home Health Care ($500 Maximum per Benefit Year.)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Skilled Nursing Care ($5,000 Maximum per Benefit Year.)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Hospice Services ($5,000 Maximum per Benefit Year.)	$0 Copay (after deductible)	$0 Copay (after deductible)	$0 Copay (after deductible)
Therapy (10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Therapies (Chiropractic, PT/OT/ST, Cardiac (Pre-certification Required)), Mental Health/Behavioral Health/Autism/Substance Abuse office visits.) • Chiropractic • PT / OT / ST • Cardiac	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Durable Medical Equipment ($500 Maximum per Benefit Year. Copayment is applied per item received.)	$50 Copay/Item (after deductible)	$50 Copay/Item (after deductible)	$50 Copay/Item (after deductible)
Infusion / Injection Drugs ($50,000 Maximum per Benefit Year. Maximum combined with chemotherapy / radiation.)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)
Chemotherapy / Radiation ($50,000 Maximum per Benefit Year. Maximum combined with infusion / Injection Drugs)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)

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Other Covered Services - Illness or Injury (Continued)			
Diabetic Services • Diabetic Nutritional Counseling - 1 Visit per Plan Year.	$0 Copay (after deductible)	$0 Copay (after deductible)	$0 Copay (after deductible)
• Diabetic Supplies / Equipment - DiaThrive: $35/Month - Non-DiaThrive: $250 Maximum per Benefit Year (after deductible).	See DiaThrive information for more details	See DiaThrive information for more details	See DiaThrive information for more details
Allergies • Shots - 25 Visits per Plan Year.	$25 Copay (after deductible)	$25 Copay (after deductible)	$25 Copay (after deductible)
• Visits / Testing - 4 Visits per Plan Year.	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)	$100 Copay/Visit (after deductible)
Prosthetics ($2,500 Maximum per Benefit Year. Copayment is applied per item received.)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)	$50 Copay/Visit (after deductible)
Dialysis	Not Covered	Not Covered	Not Covered
Organ Transplant Services	Not Covered	Not Covered	Not Covered
Child Dentistry and Eye Care • Child Eye Exam • Child Glasses / Contacts • Child Dental Check-Up	Not Covered	Not Covered	Not Covered
Prescription Drugs			
Prescription Drugs (If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.mylivepharmacy.com) • Generic Drugs	$0 Copay (See Telemedicine Formulary)	$0 Copay (See Telemedicine Formulary)	$0 Copay (See Telemedicine Formulary)
• Preferred Brand Name Drugs	$0 Copay (See Telemedicine Formulary)	$0 Copay (See Telemedicine Formulary)	$0 Copay (See Telemedicine Formulary)
• Non-Preferred Brand Name Drugs*	*PAP Available	*PAP Available	*PAP Available
• Specialty Drugs*	*PAP Available	*PAP Available	*PAP Available

***Specialty Medications**

Specialty Medications are not covered by your plan, however, medications may be separately available through Patient Assistance Program **(PAP)**. America's Choice will assist members with these applications.

TELEMEDICINE PLATFORM Highlights

Company: MyLiveDoc
- (855) 226-6567
- Email: memberservices@mylivedoc.net

NO Rx Copayments:
- Retail Pharmacy (30 Day Supply) **No Copay**
- Mail Order or Retail Pharmacy (90 Day Supply) **No Copay**

Formulary Drug List:
- www.mylivepharmacy.com

MyLiveDoc has **over 1,000 Generic Drugs available at no cost**. Please see formulary for more details.

Disclaimer: Unlimited use for this Telemedicine Platform only. This does not include your physician's telemedicine services. Telemedicine used through your physician are considered visits and are included in the 10 visit maximum per benefit year.