* America's Choice Physician & Ancillary RBP Plan Structure 2024 PRODUCT INFORMATION	\$500/\$1,000 TITANIUM	\$1,000/\$2,000 DIAMOND	\$1,500/\$3,000 PLATINUM	\$2,500/\$5,000 60LD	\$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	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED

## ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE PLAN ALLOWABLE.

## Rates effective as of June 1, 2023

Rates effective as of Julie 1, 2025										
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-Primary Care	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	Included **	\$0 Copay	Included **	\$0 Copay	20% After Deductible	\$0 Copay
TELEMEDICINE-Urgent Care	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	Included **	\$0 Copay	Included **	\$0 Copay	Included **	\$0 Copay
TELEMEDICINE-Mental Health Therapy	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	Included **	\$0 Copay	Included **	\$0 Copay	20% After Deductible	\$0 Copay
PREVENTIVE SERVICES - <u>Click Here</u> for a complete list.										
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	\$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 <b>HSA</b>	\$5,000/\$10,000 BRONZE	\$5.000/\$10.000 HSA	\$7,350/\$14,700 COPPER
Physician & Ancillary RBP Plan Structure 2024 PRODUCT INFORMATION	4000 \$1,000 TINITON		Chinese Asiana Levinian	48,000 (0,000 (0).D		40,000 97,000 OLLER	49,600 47,000 HM		40,000 ¥10,000 ION	47,000741-9700 0011 kit
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 DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	100%, AFTER DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	100%, AFTER DEDUCTIBLE, 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	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 DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	80%, AFTER DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	80%, AFTER DEDUCTIBLE, 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	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									
<b>DIAGNOSTIC TESTING</b> LAB, X-RAY	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	100%, AFTER DEDUCTIBLE, Subject to Plan Allowable								
SURGICAL SERVICES Procedures & Anesthesia	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 DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	100%, AFTER DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable	100%, AFTER DEDUCTIBLE, Subject to Plan Allowable	100%, AFTER COPAY, Subject to Plan Allowable
EMERGENCY ROOM SERVICES	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	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	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	100%, AFTER DEDUCTIBLE Subject to Plan Allowable								

*America's Choice										
Physician & Ancillary RBP Plan Structure 2024 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
MATERNITY SERVICES:								1		
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								
THERAPIES										
PHYSICAL & OCCUPATIONAL THERAPIES	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,
Limited to 20 visits combined per benefit period	Subject to Plan Allowable									
SPEECH THERAPY	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,
Limited to 20 visits per benefit period	Subject to Plan Allowable									
CARDIAC REHABILITATION THERAPY	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,
Limited to 36 visits per therapy, per benefit period	Subject to Plan Allowable									
CHIROPRACTIC SERVICES/SPINAL MANIPULATION	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,
Limited to 20 visits per benefit period	Subject to Plan Allowable									
MENTAL HEALTH CARE SERVICES: SUBJECT TO GROUP SIZE A	ND REGULATORY REQUIREMEN	NTS (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	100% AFTER DEDUCTIBLE, Subject to Plan Allowable								
OUTPATIENT MENTAL HEALTHCARE SERVICES	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
SUBSTANCE ABUSE SERVICES: SUBJECT TO GROUP SIZE AND	REGULATORY REQUIREMENTS	S (SEE PLAN DOCUMENT FOR D								
SUBSTANCE ABUSE REHABILITATION-INPATIENT	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
Paid at the facility's semi-private room rate	Subject to Plan Allowable									
SUBSTANCE ABUSE REHABILITATION-OUTPATIENT	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									
OTHER SERVICES								1		
HOME HEALTH CARE	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
60 visits per benefit period	Subject to Plan Allowable									
HOSPICE CARE	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
Residential / Facility	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	100% AFTER DEDUCTIBLE, Subject to Plan Allowable								
DURABLE MEDICAL EQUIPMENT (DME):	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
Limited to 12 month rental or purchase price, whichever is less	Subject to Plan Allowable									
PROSTHETICS AND ORTHOTIC DEVICES	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
Max amount of \$6,500 per member/per plan year	Subject to Plan Allowable									
ALL OTHER COVERED CHARGES	80% AFTER DEDUCTIBLE,	100% AFTER DEDUCTIBLE,								
	Subject to Plan Allowable									

*America's Choice	\$500/\$1,000 TITANIUM	\$1.000/\$2.000 DIAMOND	\$1,500/\$3.000 PLATINUM	\$2.500/\$5.000 60LD	\$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	
Physician & Ancillary RBP Plan Structure 2024 PRODUCT INFORMATION											
RX BENEFIT HIGHLIGHTS											
Rx Company	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	Medalist Rx	America's Pharmacy Source	
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	800-974-7036	
Website	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	MedalistRx.com	My Free Pharmacy Via America's Pharmacy Source: <u>myfreepharmacy.com</u>	
Formulary	<u>Medalist Formulary</u>	<u>Medalist Formulary</u>	Medalist Formulary	Medalist Formulary	Medalist Formulary	Medalist Formulary	Medalist Formulary	Medalist Formulary	Medalist Formulary	APS Formulary	
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		
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	APS Formulary	
	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 AI	RE NOT COVERED BY THE PLAN.	MEDICATIONS MAY BE SEPARA	FELY AVAILABLE THROUGH PHAI	RMACY IMPORTATION PROGRA	M (PIP) OR A PATIENT ASSISTAN	ICE PROGRAM (PAP). AMERICA'	S CHOICE WILL ASSIST MEMBER:	S 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.										of all services that require	
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	he 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