



## \$7,350 Value Bronze

Benefit	In-Network Providers	Out-of-Network Providers
<b>Calendar Year Deductible</b> <i>Individual / Family</i>	\$7,350 / \$14,700	\$14,700 / \$29,400
<b>Calendar Year Out-of-Pocket Maximum</b> <i>Individual / Family</i>	\$7,350 / \$14,700	Unlimited person / Unlimited family
	This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits. The balance of the family Out-of-Pocket Maximum can be satisfied by any combination of family members.	
<b>Annual Maximum Benefit</b>	Unlimited	
<b>Physician Services</b>		
<b>The Following Covered Services Have PHCS/Multiplan As the Provider Network</b>		
<b>Preventative Care Services</b> <i>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years).</i>	100%, Deductible Waived	60% Co-Insurance after Deductible
<b>Physician Office Visit</b> <i>Exam charge only</i>  <i>PCP (primary care physician) includes general practitioner, family practice, internal medicine, pediatrician, and OB/GYN.</i>	PCP: 100% Co-Insurance after Deductible  Specialist: 100% Co-Insurance after Deductible	60% Co-Insurance after Deductible
<b>Other Physician Services</b> <i>Does not include Outpatient / Independent Laboratory / Office Labs and X-Rays</i>	100% Co-Insurance after Deductible	60% Co-Insurance after Deductible
<b>Office/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services</b> <i>Does not include above services performed in conjunction with the following:</i> <i>- Emergency Room Services.</i> <i>- Urgent Care Services.</i> <i>Does not include MRI, PET or CT scans.</i>	100% Deductible does not apply	60% Co-Insurance after Deductible
<b>Facility Charges</b>		
<b>The Following Covered Services Are All Open Network</b>		
<b>Emergency Room Services</b>	120% Medicare allowable (Deductible waived)	
<b>Inpatient Hospital Services</b>	120% Medicare allowable (Deductible waived)	
<b>Outpatient Hospital Facility Charges</b>	120% Medicare allowable (Deductible waived)	
<b>Urgent Care Services</b>	120% Medicare allowable (Deductible waived)	
<b>Prescription Drug Benefit</b>		
<b>Generic</b>	100% Co-Insurance after Deductible	
<b>Preferred Brand</b>	100% Co-Insurance after Deductible	
<b>Non-Preferred Brand</b>	100% Co-Insurance after Deductible	
<b>Specialty</b>	Not Covered through Caremark; Subject to Calendar Year Deductible and coinsurance	
Allied Benefit Systems Inc. 888-989-1932 (For verification of coverage, confirmation of their PPO network, assistance <a href="http://www.alliedbenefit.com">www.alliedbenefit.com</a> )		