



\$2,000 Classic Gold

Benefit	In-Network Providers	Out-of-Network Providers
Calendar Year Deductible <i>Individual / Family</i>	\$2,000 / \$4,000	\$4,000 / \$8,000
Calendar Year Out-of-Pocket Maximum <i>Individual / Family</i>	\$7,350 / \$14,700	\$20,000 / \$40,000
	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.	
Annual Maximum Benefit	Unlimited	
Physician Services The Following Covered Services Have PHCS Practitioner Plus Ancillary Network		
Preventative Care Services <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	40% Co-Insurance after Deductible
Physician Office Visit <i>Exam charge only</i> <i>PCP (primary care physician) includes general practitioner, family practice, internal medicine, pediatrician, and OB/GYN.</i>	PCP: 100% after \$40 copay Specialist: 100% after \$80 copay	40% Co-Insurance after Deductible
Other Physician Services <i>Does not include Outpatient / Independent Laboratory / Office Labs and X-Rays</i>	30% Co-Insurance after Deductible	40% Co-Insurance after Deductible
Office/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services <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>	30% Co-Insurance after Deductible	40% Co-Insurance after Deductible
Facility Charges The Following Covered Services Are All Open Network		
Emergency Room Services	120% of the Medicare allowable Deductible Waived	
Inpatient Hospital Services	120% of the Medicare allowable Deductible Waived	
Outpatient Hospital Facility Charges	120% of the Medicare allowable Deductible Waived	
Urgent Care Services	120% of the Medicare allowable Deductible Waived	
Prescription Drug Benefit		
Generic	Retail: 0% after \$15 copay; MO: 0% after \$45 copay	
Preferred Brand	Retail: 0% after \$45 copay; MO: 0% after \$90 copay	
Non-Preferred Brand	Retail: 0% after \$85 copay; MO: 0% after \$150 copay	
Specialty	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 www.alliedbenefit.com)		