$1,000 Value Gold

Benefit	In-Network Providers	Out-of-Network Providers
Calendar Year Deductible *Individual / Family*	$1,000 / $2000	$2,000 / $4,000
Calendar Year Out-of-Pocket Maximum *Individual / Family*	$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.	
Annual Maximum Benefit	Unlimited	
Physician Services **The Following Covered Services Have PHCS/Multiplan As the Provider Network**		
Preventative Care Services *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).*	100%, Deductible Waived	40% Co-Insurance after deductible
Physician Office Visit *Exam charge only* *PCP (primary care physician) includes general practitioner, family practice, internal medicine, pediatrician, and OB/GYN.*	PCP: 100% after $50 Copay Specialist: 100% after $100 Copay	40% Co-Insurance after deductible
Other Physician Services *Does not include Outpatient / Independent Laboratory / Office Labs and X-Rays*	30% Co-insurance after deductible	40% Co-Insurance after deductible
Office/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with the following:* - *Emergency Room Services.* - *Urgent Care Services.* *Does not include MRI, PET or CT scans.*	$425 co-pay per provider per day for office and independent labs	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: $15 copay; MO $25 copay	
Preferred Brand	Retail: $65 copay; MO $87.50 copay	
Non-Preferred Brand	Retail: $100 copay; MO $162.50 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)