$3,000 Value Silver

Benefit	In-Network Providers	Out-of-Network Providers
Calendar Year Deductible *Individual / Family*	$3,000 / $6,000	$6,000 / $12,000
Calendar Year Out-of-Pocket Maximum **(excluding deductible)** *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 $60 Copay Specialist: 30% Co-Insurance after Deductible	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.*	30% coinsurance after Deductible per provider per day per office	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: $45 copay	
Preferred Brand	Retail: $65 copay; MO: $90 copay	
Non-Preferred Brand	Retail: $100 copay; MO: $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)