



**4C - \$750/100%/\$2500  
Summary of Benefits**

| Plan                                  | 4C - \$750/100%/\$2500<br>In Network                                      |
|---------------------------------------|---|
| Deductible Individual                 | \$750   |
| Deductible Family                     | \$1,500   |
| In-Network Coinsurance                | 0% coinsurance after deductible   |
| Maximum Out-of-Pocket - Individual    | \$2,500   |
| Maximum Out-of-Pocket - Family        | \$5,000   |
| Network                               | Alliant   |
| <b>Services</b>                       |   |
| Emergency Room                        | \$150   |
| Urgent Care                           | \$75  |
| Inpatient Hospital                    | \$350   |
| Inpatient Physician                   | 0% coinsurance after deductible   |
| Office Visit PCP                      | \$20  |
| Office Visit Specialist               | \$40  |
| Office Visit Mental Health            | \$20  |
| Imaging (CT/PET Scans, MRIs)          | 0% coinsurance after deductible   |
| Speech Therapy                        | 0% coinsurance after deductible   |
| Occupational/Physical Therapy         | 0% coinsurance after deductible   |
| Preventative/Screening/Immunization   | No Charge   |
| Lab Outpatient/Professional Services  | No Charge   |
| X-Rays/Diagnostic Imaging             | 0% coinsurance after deductible   |
| Skilled Nursing Facility              | 0% coinsurance after deductible   |
| Outpatient Facility (Ambulatory)      | 0% coinsurance after deductible   |
| Outpatient Surgery Physician/Surgical | 0% coinsurance after deductible   |
| Chiropractic                          | 0% coinsurance after deductible<br>In-Network Only. Limited to 20 Visits. |
| <b>Pharmacy</b>                       |   |
| Generic                               | \$15  |
| Preferred Brand                       | \$35  |
| Non-Preferred Brand                   | \$70  |
| Specialty                             | 25% coinsurance*  |
| <b>Out-of-Network</b>                 |   |
| Out-of-Network Coinsurance            | 40% coinsurance after deductible  |
| Deductible Individual                 | \$20,000  |
| Deductible Family                     | \$40,000  |

\*25% coinsurance up to \$400 maximum for any 1 (one) script.