



**4C - \$2250/100%/\$2250
Summary of Benefits**

| Plan | 4C - \$2250/100%/\$2250 In Network |
|---------------------------------------|---|
| Deductible Individual | \$2,250 |
| Deductible Family | \$4,500 |
| In-Network Coinsurance | 0% coinsurance after deductible |
| Maximum Out-of-Pocket - Individual | \$2,250 |
| Maximum Out-of-Pocket - Family | \$4,500 |
| Network | Alliant |
| Services | |
| 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/Prof Svcs | 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 | \$20 In-Network Only. Limited to 20 Visits. |
| Pharmacy | |
| Generic | \$15 |
| Preferred Brand | \$35 |
| Non-Preferred Brand | \$70 |
| Specialty | 25% coinsurance* |
| Out-of-Network | |
| 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.