



## 4C - HDHP \$6250/70%/\$6900 Plus Summary of Benefits

| Plan                                  | 4C - HDHP \$6250/70%/\$6900 Plus<br>In Network          |
|---------------------------------------|---------------------------------------------------------|
| Deductible Individual                 | \$6,250                                                 |
| Deductible Family                     | \$12,500                                                |
| In-Network Coinsurance                | 30% coinsurance after deductible                        |
| Maximum Out-of-Pocket - Individual    | \$6,900                                                 |
| Maximum Out-of-Pocket - Family        | \$13,800                                                |
| Network                               | PHCS Wrap                                               |
| <b>Services</b>                       |                                                         |
| Emergency Room                        | 30% coinsurance after deductible                        |
| Urgent Care                           | 30% coinsurance after deductible                        |
| Inpatient Hospital                    | 30% coinsurance after deductible                        |
| Inpatient Physician                   | 30% coinsurance after deductible                        |
| Office Visit PCP                      | 30% coinsurance after deductible                        |
| Office Visit Specialist               | 30% coinsurance after deductible                        |
| Office Visit Mental Health            | 30% coinsurance after deductible                        |
| Imaging (CT/PET Scans, MRIs)          | 30% coinsurance after deductible                        |
| Speech Therapy                        | 30% coinsurance after deductible                        |
| Occupational/Physical Therapy         | 30% coinsurance after deductible                        |
| Preventative/Screening/Immunization   | 0% coinsurance; not subject to deductible               |
| Lab Outpatient/Prof Svcs              | 30% coinsurance after deductible                        |
| X-Rays/Diagnostic Imaging             | 30% coinsurance after deductible                        |
| Skilled Nursing Facility              | 30% coinsurance after deductible                        |
| Outpatient Facility (Ambulatory)      | 30% coinsurance after deductible                        |
| Outpatient Surgery Physician/Surgical | 30% coinsurance after deductible                        |
| Chiropractic                          | 30% coinsurance after deductible. Limited to 20 Visits. |
| <b>Pharmacy</b>                       |                                                         |
| Generic                               | 30% coinsurance after deductible                        |
| Preferred Brand                       | 30% coinsurance after deductible                        |
| Non-Preferred Brand                   | 30% coinsurance after deductible                        |
| Specialty                             | 30% coinsurance after deductible                        |
| <b>Out-of-Network</b>                 |                                                         |
| Out-of-Network Coinsurance            | 40% coinsurance after deductible                        |
| Deductible Individual                 | \$20,000                                                |
| Deductible Family                     | \$40,000                                                |