



## 4C - HDHP \$6000/100%/\$6000 Plus Summary of Benefits

| Plan                                  | 4C - HDHP \$6000/100%/\$6000 Plus<br>In Network        |
|---------------------------------------|--------------------------------------------------------|
| Deductible Individual                 | \$6,000                                                |
| Deductible Family                     | \$12,000                                               |
| In-Network Coinsurance                | 0% coinsurance after deductible                        |
| Maximum Out-of-Pocket - Individual    | \$6,000                                                |
| Maximum Out-of-Pocket - Family        | \$12,000                                               |
| Network                               | PHCS Wrap                                              |
| <b>Services</b>                       |                                                        |
| Emergency Room                        | 0% coinsurance after deductible                        |
| Urgent Care                           | 0% coinsurance after deductible                        |
| Inpatient Hospital                    | 0% coinsurance after deductible                        |
| Inpatient Physician                   | 0% coinsurance after deductible                        |
| Office Visit PCP                      | 0% coinsurance after deductible                        |
| Office Visit Specialist               | 0% coinsurance after deductible                        |
| Office Visit Mental Health            | 0% coinsurance after deductible                        |
| 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              | 0% coinsurance after deductible                        |
| 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. Limited to 20 Visits. |
| <b>Pharmacy</b>                       |                                                        |
| Generic                               | 0% coinsurance after deductible                        |
| Preferred Brand                       | 0% coinsurance after deductible                        |
| Non-Preferred Brand                   | 0% coinsurance after deductible                        |
| Specialty                             | 0% coinsurance after deductible                        |
| <b>Out-of-Network</b>                 |                                                        |
| Out-of-Network Coinsurance            | 40% coinsurance after deductible                       |
| Deductible Individual                 | \$12,000                                               |
| Deductible Family                     | \$24,000                                               |