























Plan Benefits	HMO Silver Copay 3800		HMO Silver Coinsurance 3800		HMO Silver Coinsurance 4500	
	Select Network	Select Plus Network	Select Network	Select Plus Network	Select Network	Select Plus Network
Medical Deductible <i>Single/Family</i>	\$3,800/ \$7,600		\$3,800/ \$7,600		\$4,500 / \$9,000	
Medication Deductible <i>Single/Family</i>	\$0 / \$0		\$0 / \$0		\$0 / \$0	
Preventive Care Copay	No Cost		No Cost		No Cost	
Adult Primary Care Visit Copay	\$30		\$30		\$25	
Pediatric Primary Care Visit Copay <i>(Ages 0-19)</i>	No Cost		No Cost		No Cost	
Specialty Care Visit Copay	\$60		\$60		\$50	
Inpatient Copay	\$600 per day ¹ , not to exceed \$3,000 per stay		30% ¹		20% ¹	
Outpatient Copay	\$600 ¹		30% ¹		20% ¹	
Emergency Room Copay	\$500 ¹		\$500 ¹		\$500 ¹	
Urgent Care Copay	\$50		\$50		\$50	
Routine Lab/X-Ray Copay	No Cost		No Cost		No Cost	
Imaging (MRI, CT, Scans) Copay	\$250 per test ¹		\$250 per test ¹		\$250 per test ¹	
Medication Copays:						
<i>Tier I</i>	\$0		\$0		\$0	
<i>Tier II</i>	\$20		\$20		\$20	
<i>Tier III</i>	\$50		\$50		\$50	
<i>Tier IV</i>	\$100		\$100		\$100	
<i>Tier V</i>	40%		40%		40%	
Maximum Out-of-Pocket <i>Single/Family</i>	\$7,350 / \$14,700		\$7,350 / \$14,700		\$7,350 / \$14,700	
Plan ID	26539TX0130006-00 26539TX0130011-00		26539TX0130003-00 26539TX0130010-00		26539TX0130017-00 26539TX0130019-00	
Summary of Benefits & Coverage (SBC)						
Plan Documents						

¹After Medical Deductible

[Click here to find Select HMO Network Providers](#)

[Click here to find Select Plus HMO Network Providers](#)

Plan Benefits	HMO Silver Coinsurance 7350		HMO Silver HSA 3750		HMO Silver HSA 5000	
	Select Network	Select Plus Network	Select Network	Select Plus Network	Select Network	Select Plus Network
Medical Deductible <i>Single/Family</i>	\$7,350/ \$14,700		\$3,750/ \$7,500		\$5,000 / \$10,000	
Medication Deductible <i>Single/Family</i>	\$0 / \$0		<i>Integrated with Medical</i>		<i>Integrated with Medical</i>	
Preventive Care Copay	No Cost		No Cost		No Cost	
Adult Primary Care Visit Copay	\$25		0% ¹		0% ¹	
Pediatric Primary Care Visit Copay <i>(Ages 0-19)</i>	No Cost		No Cost		No Cost	
Specialty Care Visit Copay	\$50		0% ¹		0% ¹	
Inpatient Copay	0% ¹		0% ¹		0% ¹	
Outpatient Copay	0% ¹		0% ¹		0% ¹	
Emergency Room Copay	0% ¹		0% ¹		0% ¹	
Urgent Care Copay	\$50		0% ¹		0% ¹	
Routine Lab/X-Ray Copay	No Cost		0% ¹		0% ¹	
Imaging (MRI, CT, Scans) Copay	0% ¹		0% ¹		0% ¹	
Medication Copays:						
<i>Tier I</i>	\$0		0% ¹		0% ¹	
<i>Tier II</i>	\$20		0% ¹		0% ¹	
<i>Tier III</i>	\$50		0% ¹		0% ¹	
<i>Tier IV</i>	\$100		0% ¹		0% ¹	
<i>Tier V</i>	40%		0% ¹		0% ¹	
Maximum Out-of-Pocket <i>Single/Family</i>	\$7,350 / \$14,700		\$3,750 / \$7,500		\$5,000 / \$10,000	
Plan ID	26539TX0130025-00 26539TX0130026-00		26539TX0130016-00 26539TX0130015-00		26539TX0130027-00 26539TX0130028-00	
Summary of Benefits & Coverage (SBC)						
Plan Documents						

¹After Medical Deductible

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