





Plan Benefits	HMO Gold Coinsurance	HMO Gold Copay
<b>Medical Deductible</b> <i>Single/Family</i>	\$1,200 / \$2,400	\$0 / \$0
<b>Medication Deductible</b> <i>Single/Family</i>	\$0 / \$0	\$0 / \$0
<b>Preventive Care Copay</b>	No Cost	No Cost
<b>Adult Primary Care Visit Copay</b>	\$30	\$30
<b>Pediatric Primary Care Visit Copay</b> <i>(Ages 0-19)</i>	\$0	\$0
<b>Specialty Care Visit Copay</b>	\$50	\$50
<b>Inpatient Copay</b>	20% <sup>1</sup>	\$700 per day, not to exceed \$3,500 per stay
<b>Outpatient Copay</b>	20% <sup>1</sup>	\$600
<b>Emergency Room Copay</b>	\$500 <sup>1</sup>	\$500
<b>Urgent Care Copay</b>	\$50	\$50
<b>Routine Lab/X-Ray Copay</b>	No Cost	No Cost
<b>Imaging (MRI, CT, Scans) Copay</b>	\$250 per test <sup>1</sup>	\$250 per test
<b>Medication Copays:</b>		
<i>Tier I</i>	\$0	\$0
<i>Tier II</i>	\$10	\$20
<i>Tier III</i>	\$50	\$50
<i>Tier IV</i>	\$100	\$100
<i>Tier V</i>	30%	30%
<b>Formulary</b>	<a href="#">Click here</a>	<a href="#">Click here</a>
<b>Compare Medication Costs</b>	<a href="#">Click here</a>	<a href="#">Click here</a>
<b>Maximum Out-of-Pocket</b> <i>Single/Family</i>	\$4,600 / \$9,200	\$7,150 / \$14,300
<b>Plan ID</b>	26539TX0140001-01	26539TX0140002-00
<b>Summary of Benefits &amp; Coverage (SBC)</b>		
<b>Plan Documents</b>		

<sup>1</sup>After Medical Deductible

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