









| Plan Benefits   | HMO Bronze<br>Coinsurance 6650  |  | HMO Bronze<br>HSA 6650  |   |
|---|---|--|---|---|
| <b>Medical Deductible</b><br><i>Single/Family</i>               | \$6,650 / \$13,300  |  | \$6,550 / \$13,100  |   |
| <b>Medication Deductible</b><br><i>Single/Family</i>            | <i>Integrated with Medical<br/>(Tiers III-IV only)</i>                              |  | <i>Integrated with Medical</i>  |   |
| <b>Preventive Care Copay</b>                                    | No Cost   |  | No Cost   |   |
| <b>Adult Primary Care Visit Copay</b>                           | \$35  |  | 0% <sup>1</sup>   |   |
| <b>Pediatric Primary Care Visit Copay</b><br><i>(Ages 0-19)</i> | \$0   |  | 0% <sup>1</sup>   |   |
| <b>Specialty Care Visit Copay</b>                               | \$75  |  | 0% <sup>1</sup>   |   |
| <b>Inpatient Copay</b>  | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Outpatient Copay</b>   | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Emergency Room Copay</b>                                     | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Urgent Care Copay</b>  | \$75  |  | 0% <sup>1</sup>   |   |
| <b>Routine Lab/X-Ray Copay</b>                                  | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Imaging (MRI, CT, Scans) Copay</b>                           | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Medication Copays:</b>                                       |   |  |   |   |
| <i>Tier I</i>   | \$0   |  | 0% <sup>1</sup>   |   |
| <i>Tier II</i>  | \$35  |  | 0% <sup>1</sup>   |   |
| <i>Tier III</i>   | 35% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <i>Tier IV</i>  | 40% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <i>Tier V</i>   | 45% <sup>1</sup>  |  | 0% <sup>1</sup>   |   |
| <b>Maximum Out-of-Pocket</b><br><i>Single/Family</i>            | \$7,350 / \$14,700  |  | \$6,550 / \$13,100  |   |
| <b>Plan ID</b>  | 26539TX0130021-00<br>26539TX0130022-00  |  | 26539TX0130007-00<br>26539TX0130014-00  |   |
|   | <i>Select<br/>Network</i>   | <i>Select Plus<br/>Network</i>   | <i>Select<br/>Network</i>   | <i>Select Plus<br/>Network</i>  |
| <b>Summary of Benefits &amp; Coverage (SBC)</b>                 |  |  |  |  |
| <b>Plan Documents</b>   |  |  |  |  |

<sup>1</sup>After Medical Deductible

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

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