





Plan Benefits	HMO Gold Coinsurance (\$1950)	HMO Gold Copay (\$0)
Medical Deductible <i>Single/Family</i>	\$1,950 / \$3,900	\$0 / \$0
Medication Deductible <i>Single/Family</i>	\$0 / \$0	\$0 / \$0
Preventive Care Copay	No Cost	No Cost
Adult Primary Care Visit Copay	\$30	\$30
Pediatric Primary Care Visit Copay <i>(Ages 0-19)</i>	\$0	\$0
Specialty Care Visit Copay	\$50	\$50
Inpatient Copay	20% ¹	\$700 per day not to exceed \$3,500 per stay
Outpatient Copay	20% ¹	\$600
Emergency Room Copay	\$500 ¹	\$500
Urgent Care Copay	\$50	\$50
Routine Lab/X-Ray Copay	20% ¹	20%
Imaging (MRI, CT, Scans) Copay	\$250 per test ¹	\$250 per test
Telehealth <i>Coverage to include FirstCare Virtual Care powered by MDLIVE</i>	No Cost	No Cost
Medication Copays:		
<i>Tier I</i>	\$0	\$0
<i>Tier II</i>	\$20	\$20
<i>Tier III</i>	\$50	\$50
<i>Tier IV</i>	\$125	\$125
<i>Tier V</i>	30%	30%
Formulary	Click here	Click here
Compare Medication Costs	Click here	Click here
Maximum Out-of-Pocket <i>Single/Family</i>	\$6,600 / \$13,200	\$7,900 / \$15,800
Plan ID	26539TX0140001-01	26539TX0140002-00
Summary of Benefits & Coverage (SBC)		
Plan Documents		

¹After Medical Deductible