

	HMO Flex C1F1—\$10/\$20/\$35	HMO 2—\$1/\$3	HMO 10—\$8/\$14
MEDICAL BENEFITS			
Deductible (Individual; Family)	NA	NA	NA
Coinsurance	NA	NA	NA
Out-of-Pocket Maximum (Per Member; Per Family)	\$7,150; \$14,300	\$6,600; \$13,200	\$6,600; \$13,200
Alcohol/Drug Inpatient	No charge	No charge	No charge
Alcohol/Drug Outpatient	\$20 copay	No charge	\$15 copay
Ambulance	No charge	No charge	No charge
Blood	\$20 copay	No charge	No charge
Diabetic Equipment & Supplies and Medical/Consumable	30% of contracted fee schedule for a DME provider	No charge	No charge
Diagnostic—Routine; Non-Routine	\$20 copay; \$40 copay	No charge	No charge
Emergency Care Services	\$100 copay (waived if admitted)	\$15 copay (waived if admitted)	\$35 copay (waived if admitted)
Hospital Services	No charge	No charge	No charge
Injectable Medications - Specialty	\$50 copay	No charge	No charge
Maternity/OB Care Prof. Svc	\$10 copay	\$0 copay	\$15 copay
Mental Health Inpatient	No charge	No charge	No charge
Mental Health Outpatient	\$20 copay	\$0 copay	\$15 copay
Preventive Care Services	No charge	No charge	No charge
PCP Office Visits - Non-Preventive	\$10 copay	\$2 copay	\$10 copay
Specialist Office Visit	\$20 copay	No charge	\$15 copay
Spinal Manipulation	\$20 copay	No charge	No charge
Surgical - 2nd Opinion	\$20 copay	No charge	\$15 copay
Outpatient Surgery	No charge	No charge	No charge
Therapy Ortho/Pleoptic and Rehab	\$20 copay (Cardiac, Pulm, Speech \$20 copay)	No charge	No charge
Urgent Care	\$70 copay	\$10 copay	\$24 copay
OUT-OF-NETWORK BENEFITS			
Deductible	NA	NA	NA
Coinsurance (% Plan Pays)	NA	NA	NA
Out-of-Pocket Maximum	NA	NA	NA
PRESCRIPTION BENEFITS			
Retail Pharmacy			
Generic	\$10	\$1	\$8
Preferred	\$20	\$3	\$14
Non-Preferred	\$35	\$3	\$14