2018 PLAN DESIGNS – DEDUCTIBLE & COPAY

MEMBER COST SHARE	*High Deductible Health Plan HSA Compatible Plan ID 27248TX0010008	✤HMO Bronze Deductible 003 Plan ID 27248TX0010003	Community Health Choice HMO Silver Deductible Plans 004** Plan ID 27248TX0010004				*Gold Deductible 005 Plan ID 27248TX0010005	Community Health Choice HMO Silver Copay 002 & 007 Plan ID's 27248TX0010002 & 27248TX0010007				Gold Copay 001 & 006 Plan ID's 27248TX0010001 & 27248TX0010006
			*Silver Deductible 004 250% FPL and above	*Silver Deductible 004 (73) 200%-249% FPL	Silver Deductible 004 (87) 150%-199% FPL	Silver Deductible 004 (94) 100%-149% FPL		Silver Copay 002 & 007 250% FPL and above	Silver 002 & 007 Copay (73) 200%-249% FPL	Silver 002 & 007 Copay (87) 150%-199% FPL	Silver 002 & 007 Copay (94) 100%-149% FPL	
Medical Deductible (individual/family)*	$6,000 / $12,000	$6,000 / $12,000	$2,500 / $5,000	$2,000 / $4,000	$0	$0	$500 / $1,000	$0	$0	$0	$0	$0
Out-of-Pocket Max (individual/family)	$6,000 / $12,000	$7,350 / $14,700	$7,350 / $14,700	$5,850 / $11,700	$2,450 / $4,900	$1,400 / $2,800	$5,000 / $10,000	$7,350 / $14,700	$5,850 / $11,700	$2,450 / $4,900	$1,400 / $2,800	$7,350 / $14,700
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE											
PCP Office Visit	No charge after deductible	$40	$30	$30	$15	$10	$20	$40	$40	$15	$10	$30
Specialist Office Visit		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Outpatient Facility		$400	$200	$200	$150	$30	$150	$300	$300	$150	$30	$150
Outpatient Surgery		$400	$200	$200	$150	$30	$150	$300	$300	$150	$30	$150
Urgent Care Services		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Ambulance Services		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Emergency Room Services		30%	$500	$500	$300	$100	$400	$600	$600	$300	$100	$400
Inpatient Hospital Care**		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Inpatient Skilled Nursing Facility**		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Outpatient Mental/Behavioral Substance Abuse		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Inpatient Mental/Behavioral Substance Abuse**		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Outpatient Rehabilitation		$65	$50	$50	$50	$10	$45	$75	$75	$50	$10	$65
Medical Imaging (CT/PET Scans, MRIs)		$500	$500	$500	$300	$100	$400	$350	$350	$300	$100	$300
Routine Lab/X-Ray/Diagnostic Imaging		$40	$30	$30	$15	$10	$20	$40	$40	$15	$10	$30
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE											
Prescription Drug Deductible (individual/family)*	$0	$200 / $400	$0	$0	$0	$0	$0	$350 / $700	$350 / $700	$0	$0	$0
Generic	No charge after deductible	$10 ♦	$10	$10	$10	$5	$10	$35	$25	$10	$5	$15
Preferred Brand		$60 ♦	$50	$40	$35	$20	$40	$110 ♦	$110 ♦	$35	$20	$40
Non-Preferred Brand		$110 ♦	$100	$90	$70	$40	$70	$120 ♦	$120 ♦	$70	$40	$80
Specialty High Cost Drugs		40% ♦	45%	40%	30%	20%	30%	50% ♦	50% ♦	30%	20%	30%

* All coinsurance/copays apply after annual deductible has been met
** Copay applies for first 5 days of admission

♦ All coinsurance/copays apply after prescription drug deductible has been met
✤ For Bronze 003 deductible plan, 3 PCP office visits are covered at the PCP copay prior to deductible

DISEÑOS DE PLAN 2018 – DEDUCIBLE Y COPAGOS

PAGO COMPARTIDO DEL MIEMBRO	***Plan de Alto Deducible HSA Compatible 008** ID de Plan 27248TX0010008	**✤Plan con Deducibles Bronce 003** ID de Plan 27248TX0010003	**Planes con Deducibles Plata de Community Health Choice HMO 004**** ID de Plan 27248TX0010004				***Plan con Deducibles Oro 005** ID de Plan 27248TX0010005	**Planes con Copago Plata de Community Health Choice HMO** ID de Plan 27248TX0010002 & 27248TX0010007				**Copago Oro 001 & 006** ID de Plan 27248TX0010001 & 27248TX0010006
			***Plan con Deducibles Plata 004** 250% FPL y más	***Plan con Deducibles Plata 004 004 (73)** 200%-249% FPL	***Plan con Deducibles Plata 004 004 (87)** 150%-199% FPL	***Plan con Deducibles Plata 004 004 (94)** 100%-149% FPL		**Copago Plata 002 & 007** 250% FPL y más	**Copago Plata 002 & 007 (73)** 200%-249% FPL	**Copago Plata 002 & 007 (87)** 150%-199% FPL	**Copago Plata 002 & 007 (94)** 100%-149% FPL	
Deducible Médico (individual/familia)	$6,000 / $12,000	$6,000 / $12,000	$2,500 / $5,000	$2,000 / $4,000	$0	$0	$500 / $1,000	$0	$0	$0	$0	$0
Gasto de su bolsillo máximo (individual/familia)	$6,000 / $12,000	$7,350 / $14,700	$7,350 / $14,700	$5,850 / $11,700	$2,450 / $4,900	$1,400 / $2,800	$5,000 / $10,000	$7,350 / $14,700	$5,850 / $11,700	$2,450 / $4,900	$1,400 / $2,800	$7,350 / $14,700
BENEFICIOS MÉDICOS	COPAGOS Y COSEGUROS DEL MIEMBRO											
Visita a su médico de cabecera (médico de cuidado primario)	no cargo después de deductible	$40	$30	$30	$15	$10	$20	$40	$40	$15	$10	$30
Visita al médico especialista		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Centro Ambulatorio		$400	$200	$200	$150	$30	$150	$300	$300	$150	$30	$150
Cirugía Ambulatoria		$400	$200	$200	$150	$30	$150	$300	$300	$150	$30	$150
Servicios de Cuidado de Urgencias		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Servicio de Ambulancia		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Servicios de Salas de Emergencia		30%	$500	$500	$300	$100	$400	$600	$600	$300	$100	$400
Cuidado hospitalario (Cuidados de paciente hospitalizado)**		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Inpatient Skilled Nursing Facility**		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Salud del Comportamiento/ Mental Ambulatoria		$65	$50	$50	$50	$20	$45	$75	$75	$50	$20	$65
Salud del Comportamiento/ Mental Hospitalaria		30%	$500	$500	$300	$200	$400	$600	$600	$300	$200	$400
Rehabilitación ambulatoria		$65	$50	$50	$50	$10	$45	$75	$75	$50	$10	$65
Imágenes Médicas (TC/Escaneos PET, Resonancias Magnéticas)		$500	$500	$500	$300	$100	$400	$350	$350	$300	$100	$300
Routine Lab/X-Ray/Diagnostic Imaging		$40	$30	$30	$15	$10	$20	$40	$40	$15	$10	$30
MEDICAMENTOS CON PRESCRIPCIÓN	COPAGOS Y COSEGUROS DEL MIEMBRO											
Prescription Drug Deductible (individual/family)*	$0	$200 / $400	$0	$0	$0	$0	$0	$350 / $700	$350 / $700	$0	$0	$0
Genéricos	no cargo después de deductible	$10 ♦	$10	$10	$10	$5	$10	$35	$25	$10	$5	$15
Marcas Preferidas		$60 ♦	$50	$40	$35	$20	$40	$110 ♦	$110 ♦	$35	$20	$40
Marcas no Preferidas		$110 ♦	$100	$90	$70	$40	$70	$120 ♦	$120 ♦	$70	$40	$80
Medicamentos Especializados de Alto Costo		40% ♦	45%	40%	30%	20%	30%	50% ♦	50% ♦	30%	20%	30%

* Todos los coseguro/copagos se aplican después de que se ha cumplido el requisito anual
** El copago se aplica por día durante los primeros 5 días
♦ Todos los coseguro/copagos se aplican después de que se ha cumplido el deductible de medicamentos con prescripción
✤ Para nuestro plan Bronce, recibirá 3 visitas al consultorio para ver a su médico de cabecera a nivel de copago, antes de cumplir con su deducible

COMMUNITY HEALTH CHOICE
CUIDANDO NUESTRA COMUNIDAD.