2020 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 009** Plan ID 27248TX0010009				**Community Health Choice HMO Silver Deductible Plans 004** Plan ID 27248TX0010004				**Gold Deductible 005** Plan ID 27248TX0010005	**Gold Copay 001** Plan ID 27248TX0010001
			Silver Deductible 009 250% FPL and above	**Silver Deductible 009 (73)** 200%-249% FPL	**Silver Deductible 009 (87)** 150%-199% FPL	**Silver Deductible 009 (94)** 100%-149% FPL	**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		
Medical Deductible (individual/family)	$6,750 / $13,500	$7,150 / $14,300	$5,000 / $10,000	$2,500 / $5,000	N/A	N/A	$3,000 / $6,000	$2,800 / $5,600	N/A	N/A	$750 / $1,500	N/A
Out-of-Pocket Max (individual/family)	$6,750 / $13,500	$8,150 / $16,300	$7,000 / $14,000	$6,000 / $12,000	$2,700 / $5,400	$2,500 / $5,000	$7,900 / $15,800	$6,500 / $13,000	$2,700 / $5,400	$2,500 / $5,000	$6,500 / $13,000	$8,150 / $16,300
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE											
PCP Office Visit	No charge after deductible	*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Specialist Office Visit		*$70	$60	$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Outpatient Facility		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Outpatient Surgery		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Urgent Care Services		*$70	*$60	*$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Ambulance Services		$70	$60	$60	$50	$20	$60	$50	$50	$20	$40	$65
Emergency Room Services		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$700
Inpatient Hospital Care		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Inpatient Skilled Nursing Facility		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Outpatient Mental/Behavioral Substance Abuse		*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Inpatient Mental/Behavioral Substance Abuse		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Outpatient Rehabilitation		$70	$60	$60	$50	$10	$60	$50	$50	$10	$40	$65
Medical Imaging (CT/PET Scans, MRIs)		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$500
Routine Lab/X-Ray/ Diagnostic Imaging		$40	$30	$30	$25	$10	$30	$25	$25	$10	$20	$30
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE											
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A	Combined with Medical Deductible	N/A
Generic	No charge after deductible	*$15	*$15	*$10	$10	$5	*$10	*$10	$10	$5	*$10	$20
Preferred Brand		$70	$70	$50	$50	$20	$60	$50	$50	$20	$40	$40
Non-Preferred Brand		$120	$120	$100	$85	$40	$100	$90	$85	$40	$70	$80
Specialty High-Cost Drugs		45%	45%	45%	30%	20%	45%	40%	30%	20%	30%	30%

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* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
** Copay applies for first 5 days of admission for all inpatient services
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

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