COMMUNITY PREMIER BRONZE PLAN 17

27248TX0010017

Lowest Premiums
Higher Deductibles

DETAILS

- Telehealth services available.
- Referrals not required to see Specialist.
- Preventive care is available at no cost.
- Out-of-network services are not covered under this plan.
- Prior Authorization/Step Therapy requirements apply to some medical and pharmacy benefits.

Benefits	Cost Sharing Levels
Deductible (individual/family)	$9,100 / $18,200
Maximum Out-of-Pocket Costs (individual/family)	$9,100 / $18,200
MEDICAL	
PCP Office Visit	No charge after deductible
Specialist Office Visit	
Outpatient Facility	
Outpatient Surgery	
Urgent Care Services	
Ambulance Services	
Emergency Room Services	
Inpatient Hospital Care	
Inpatient Skilled Nursing Facility	
Outpatient Mental/Behavioral Substance Abuse	
Inpatient Mental/Behavioral Substance Abuse	
Outpatient Rehabilitation	
Medical Imaging (CT/PET Scans, MRIs)	
Routine Lab/X-Ray/Diagnostic Imaging	
PRESCRIPTION DRUGS	
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible
Generic	No charge after deductible
Preferred Brand	No charge after deductible
Non-Preferred Brand	No charge after deductible
Specialty High-Cost Drugs	No charge after deductible

For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.