

COMMUNITY PREMIER GOLD PLAN 001

27248TX0010001

Moderate Monthly Premiums
Low-to-Moderate Cost-Sharing

DETAILS

- Telehealth services available.
- Referrals not required to see Specialist.
- Preventive care is available at no cost.
- No medical or pharmacy deductible.
- 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)	N/A
Maximum Out-of-Pocket Costs (individual/family)	\$9,100 / \$18,200
MEDICAL	
PCP Office Visit	\$30
Specialist Office Visit	\$65
Outpatient Facility	\$300
Outpatient Surgery	\$300
Urgent Care Services	\$65
Ambulance Services	\$65
Emergency Room Services	\$800
Inpatient Hospital Care	\$800**
Inpatient Skilled Nursing Facility	\$800**
Outpatient Mental/Behavioral Substance Abuse	\$30
Inpatient Mental/Behavioral Substance Abuse	\$800**
Outpatient Rehabilitation	\$65
Medical Imaging (CT/PET Scans, MRIs)	\$500
Routine Lab/X-Ray/Diagnostic Imaging	\$30
PRESCRIPTION DRUGS	
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	N/A
Generic	\$20
Preferred Brand	\$40
Non-Preferred Brand	\$80
Specialty High-Cost Drugs	30%

** Copay applies for first 5 days of admission for all inpatient services.