

COMMUNITY PREMIER SILVER PLAN 004

27248TX0010004

Higher Premiums

Low-to-Moderate Cost Sharing

DETAILS

- PCP, Specialist, urgent care, and generic drugs are not subject to deductible.
- Telehealth services available.
- Referrals not required to see Specialist.
- Preventative 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)	\$3,300 / \$6,600
Maximum Out-of-Pocket Costs (individual/family)	\$9,100 / \$18,200
MEDICAL	
PCP Office Visit	\$30*
Specialist Office Visit	\$60*
Outpatient Facility	40%
Outpatient Surgery	40%
Urgent Care Services	\$60*
Ambulance Services	\$60
Emergency Room Services	40%
Inpatient Hospital Care	40%
Inpatient Skilled Nursing Facility	40%
Outpatient Mental/Behavioral Substance Abuse	\$30*
Inpatient Mental/Behavioral Substance Abuse	40%
Outpatient Rehabilitation	\$60
Medical Imaging (CT/PET Scans, MRIs)	40%
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)	Combined with Medical Deductible
Generic	\$10*
Preferred Brand	\$70
Non-Preferred Brand	\$110
Specialty High-Cost Drugs	50%

*Services are exempt from deductible where indicated (PCP/Urgent Care/Generic Rx).

†Cost sharing may be lower for those who are eligible for increased cost sharing subsidies.

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

communityhealthchoice.org

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