COMMUNITY PREMIER SILVER PLAN 12

27248TX0010012

Higher Premiums
Low-to-Moderate Cost Sharing

DETAILS

- PCP, 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)	$3,000 / $6,000
Maximum Out-of-Pocket Costs (individual/family)	$9,100 / $18,200
MEDICAL	
PCP Office Visit	$30*
Specialist Office Visit	$60
Outpatient Facility	50%
Outpatient Surgery	50%
Urgent Care Services	$60*
Ambulance Services	$60
Emergency Room Services	50%
Inpatient Hospital Care	50%
Inpatient Skilled Nursing Facility	50%
Outpatient Mental/Behavioral Substance Abuse	$30*
Inpatient Mental/Behavioral Substance Abuse	50%
Outpatient Rehabilitation	$60 copay
Medical Imaging (CT/PET Scans, MRIs)	50%
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	$80
Non-Preferred Brand	$120
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.

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