COMMUNITY PREMIER BRONZE PLAN 003

27248TX0010003

Lowest Premium Costs
Higher Out-Of-Pocket Costs for Services

DETAILS

- PCP, urgent care, and generic drugs are not subject to deductible.
- Telehealth services available.
- Referrals not required to see specialists.
- 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)	$7,700 / $15,400
Maximum Out-of-Pocket Costs (individual/family)	$9,450 / $18,900
MEDICAL	
PCP Office Visit	$40*
Specialist Office Visit	$70
Outpatient Facility	40%
Outpatient Surgery	40%
Urgent Care Services	$70*
Ambulance Services	$70
Emergency Room Services	40%
Inpatient Hospital Care	40%
Inpatient Skilled Nursing Facility	40%
Outpatient Mental/Behavioral Substance Abuse	$40*
Inpatient Mental/Behavioral Substance Abuse	40%
Outpatient Rehabilitation	$70
Medical Imaging (CT/PET Scans, MRIs)	40%
Routine Lab/X-Ray/Diagnostic Imaging	$40
PRESCRIPTION DRUGS	
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible
Generic	$16*
Preferred Brand	$70
Non-Preferred Brand	$120
Specialty High-Cost Drugs	45%

*Services are exempt from deductible where indicated (PCP/Urgent Care/Generic Rx).
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

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COMMUNITY HEALTH CHOICE
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