COMMUNITY PREMIER GOLD PLAN 001

27248TX0010003

Moderate Monthly Premiums
Low-to-Moderate Cost-Sharing

DETAILS

- Telehealth services available.
- Referrals not required to see specialists.
- 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)	$9,450 / $18,900
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	$25
Preferred Brand	$40
Non-Preferred Brand	$80
Specialty High-Cost Drugs	30%

*Services are exempt from deductible where indicated (PCP/Urgent Care/Generic Rx).
** Copay applies for first 5 days of admission for all inpatient services.
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

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COMMUNITY HEALTH CHOICE
COMMUNITY CARES