

COMMUNITY PREMIER GOLD PLAN 021

27248TX0010021

Moderate Monthly Premiums
Low Cost-Sharing

DETAILS

- PCP, specialists, urgent care, and generic drugs are not subject to deductible.
- Telehealth services available.
- Referrals not required to see specialists.
- Preventive 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)	\$1,500 / \$3,000
Maximum Out-of-Pocket Costs (individual/family)	\$8,700 / \$17,400
MEDICAL	
PCP Office Visit	\$30*
Specialist Office Visit	\$60*
Outpatient Facility	25%
Outpatient Surgery	25%
Urgent Care Services	\$45*
Ambulance Services	\$60
Emergency Room Services	25%
Inpatient Hospital Care	25%
Inpatient Skilled Nursing Facility	25%
Outpatient Mental/Behavioral Substance Abuse	\$30*
Inpatient Mental/Behavioral Substance Abuse	25%
Outpatient Rehabilitation	\$30*
Medical Imaging (CT/PET Scans, MRIs)	25%
Routine Lab/X-Ray/Diagnostic Imaging	25%
PRESCRIPTION DRUGS	
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible
Generic	\$15*
Preferred Brand	\$30*
Non-Preferred Brand	\$60*
Specialty High-Cost Drugs	\$250*

*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.