

COMMUNITY PREMIER SILVER PLAN 12

27248TX0010012

Higher Premiums
Mid-Level Deductible

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)	\$3,000 / \$6,000
Maximum Out-of-Pocket Costs (individual/family)	\$9,450 / \$18,900
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
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).
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.