

COMMUNITY PREMIER SILVER PLAN 13

27248TX0010013

Higher Premiums
High Deductible

DETAILS

- PCP, specialists, 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)	\$9,100 / \$18,200
Maximum Out-of-Pocket Costs (individual/family)	\$9,100 / \$18,200
MEDICAL	
PCP Office Visit	\$10*
Specialist Office Visit	\$20*
Outpatient Facility	No charge after deductible
Outpatient Surgery	
Urgent Care Services	\$20*
Ambulance Services	No charge after deductible
Emergency Room Services	
Inpatient Hospital Care	
Inpatient Skilled Nursing Facility	
Outpatient Mental/Behavioral Substance Abuse	\$10*
Inpatient Mental/Behavioral Substance Abuse	No charge after deductible
Outpatient Rehabilitation	
Medical Imaging (CT/PET Scans, MRIs)	
Routine Lab/X-Ray/Diagnostic Imaging	
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	No charge after deductible
Non-Preferred Brand	
Specialty High-Cost Drugs	

*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.