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)	$7,800 / $15,600
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.

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COMMUNITY HEALTH CHOICE
COMMUNITY CARES