COMMUNITY 2021 PLAN DESIGNS

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COMMUNITY HEALTH CHOICE

BRONZE	**Vital Bronze 003** Plan ID 27248TX0010003	**Essential Bronze 008 HSA** Plan ID 27248TX0010008	**Value Bronze 10** Plan ID 27248TX0010010	**Virtual Now Bronze 11** Plan ID 27248TX0010011
Medical Deductible (individual/family)	$7,700 / $15,400	$7,000 / $14,000	$8,550 / $17,100	$8,550 / $17,100
Out-of-Pocket Max (individual/family)	$8,550 / $17,100	$7,000 / $14,000	$8,550 / $17,100	$8,550 / $17,100
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$40	No charge after deductible	No charge after deductible	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible
Specialist Office Visit	$70			No charge after deductible
Outpatient Facility	40%			
Outpatient Surgery	40%			
Urgent Care Services	*$70			
Ambulance Services	$70			
Emergency Room Services	40%			
Inpatient Hospital Care	40%			
Inpatient Skilled Nursing Facility	40%			
Outpatient Mental/Behavioral Substance Abuse	*$40			*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible
Inpatient Mental/Behavioral Substance Abuse	40%			No charge after deductible
Outpatient Rehabilitation	$70			
Medical Imaging (CT/PET Scans, MRIs)	40%			
Routine Lab/X-Ray/Diagnostic Imaging	$40			
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$16	No charge after deductible	No charge after deductible	No charge after deductible
Preferred Brand	$70			
Non-Preferred Brand	$120			
Specialty High-Cost Drugs	45%			

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

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GOLD	**Enhanced Gold 005** Plan ID 27248TX0010005	**Elite Gold 001** Plan ID 27248TX0010001	**Elite Gold HSA 14** Plan ID 27248TX0010014
Medical Deductible (individual/family)	$2,000/ $4,000	N/A	$2,000/ $4,000
Out-of-Pocket Max (individual/family)	$8,550 / $17,100	$8,150 / $16,300	$6,000 / $12,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE		
PCP Office Visit	*$20	$30	$20
Specialist Office Visit	*$40	$65	$35
Outpatient Facility	25%	$300	20%
Outpatient Surgery	25%	$300	20%
Urgent Care Services	*$40	$65	$35
Ambulance Services	$40	$65	$35
Emergency Room Services	25%	$700	20%
Inpatient Hospital Care	25%	**$700	20%
Inpatient Skilled Nursing Facility	25%	**$700	20%
Outpatient Mental/Behavioral Substance Abuse	*$20	$30	$20
Inpatient Mental/Behavioral Substance Abuse	25%	**$700	20%
Outpatient Rehabilitation	$40	$65	$35
Medical Imaging (CT/PET Scans, MRIs)	25%	$500	20%
Routine Lab/X-Ray/Diagnostic Imaging	$20	$30	$20
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE		
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	N/A	Combined with Medical Deductible
Generic	*$10	$20	$5
Preferred Brand	$50	$40	$80
Non-Preferred Brand	$75	$80	$100
Specialty High-Cost Drugs	35%	30%	40%

* Services are exempt from deductible where indicated (PCP/Specialist/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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SILVER	**Community Standard Preferred Silver 009** Plan ID 27248TX0010009				**Community Advance Preferred Silver 004** Plan ID 27248TX0010004			
	Silver 009 250% FPL and above	**Silver 009 (73)** 200%-249% FPL	**Silver 009 (87)** 150%-199% FPL	**Silver 009 (94)** 100%-149% FPL	**Silver 004** 250% FPL and above	**Silver 004 (73)** 200%-249% FPL	**Silver 004 (87)** 150%-199% FPL	**Silver 004 (94)** 100%-149% FPL
Medical Deductible (individual/family)	$5,000 / $10,000	$3,000 / $6,000	N/A	N/A	$3,000 / $6,000	$2,900 / $5,800	N/A	N/A
Out-of-Pocket Max (individual/family)	$7,000 / $14,000	$6,800 / $13,600	$2,850 / $5,700	$2,500 / $5,000	$8,550 / $17,100	$6,800 / $13,600	$2,850 / $5,700	$2,500 / $5,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	$25	$10	*$30	*$30	$25	$10
Specialist Office Visit	$60	$60	$50	$20	*$60	*$60	$50	$20
Outpatient Facility	30%	30%	30%	10%	40%	40%	40%	10%
Outpatient Surgery	30%	30%	30%	10%	40%	40%	40%	10%
Urgent Care Services	$60	$60	$50	$20	*$60	*$60	$50	$20
Ambulance Services	$60	$60	$50	$20	$60	$60	$50	$20
Emergency Room Services	30%	30%	30%	10%	40%	40%	40%	10%
Inpatient Hospital Care	30%	30%	30%	10%	40%	40%	40%	10%
Inpatient Skilled Nursing Facility	30%	30%	30%	10%	40%	40%	40%	10%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	$25	$10	*$30	*$30	$25	$10
Inpatient Mental/Behavioral Substance Abuse	30%	30%	30%	10%	40%	40%	40%	10%
Outpatient Rehabilitation	$60	$60	$50	$10	$60	$60	$50	$10
Medical Imaging (CT/PET Scans, MRIs)	30%	30%	30%	10%	40%	40%	40%	10%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10	$30	$30	$25	$10
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A
Generic	*$15	*$10	$10	$5	*$10	*$10	$10	$5
Preferred Brand	$70	$60	$50	$20	$70	$60	$50	$20
Non-Preferred Brand	$120	$110	$85	$40	$110	$100	$85	$40
Specialty High-Cost Drugs	45%	45%	30%	20%	50%	40%	30%	20%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

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SILVER	**Community Standard Silver 12** Plan ID 27248TX0010012				**Community Advance Silver 13** Plan ID 27248TX0010013			
	Silver 12 250% FPL and above	**Silver 12 (73)** 200%-249% FPL	**Silver 12 (87)** 150%-199% FPL	**Silver 12 (94)** 100%-149% FPL	**Silver 13** 250% FPL and above	**Silver 13 (73)** 200%-249% FPL	**Silver 13 (87)** 150%-199% FPL	**Silver 13 (94)** 100%-149% FPL
Medical Deductible (individual/family)	$6,000 / $12,000	$2,500 / $5,000	$500 / $1,000	N/A	$8,550 / $17,100	$6,800 / $13,600	$2,300 / $4,600	$750 / $1,500
Out-of-Pocket Max (individual/family)	$8,550 / $17,100	$6,800 / $13,600	$2,850 / $5,700	$2,700 / $5,400	$8,550 / $17,100	$6,800 / $13,600	$2,300 / $4,600	$750 / $1,500
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$25	$10	*$30	*$10	*$10	*$5
Specialist Office Visit	$60	$60	$50	$20	*$60	*$15	*$15	*$10
Outpatient Facility	50%	50%	30%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery	50%	50%	30%	10%				
Urgent Care Services	*$60	*$60	*$50	$20	*$60	*$15	*$15	*$10
Ambulance Services	$60	$60	$50	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Room Services	50%	50%	40%	10%				
Inpatient Hospital Care	50%	50%	40%	10%				
Inpatient Skilled Nursing Facility	50%	50%	40%	10%				
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$25	$10	*$30	*$10	*$10	*$5
Inpatient Mental/Behavioral Substance Abuse	50%	50%	40%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Rehabilitation	$60	$60	$50	$20				
Medical Imaging (CT/PET Scans, MRIs)	50%	50%	40%	10%				
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10				
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$10	*$10	*$5	$5	*$10	*$5	*$5	*$5
Preferred Brand	$80	$80	$70	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Non-Preferred Brand	$120	$120	$100	$40				
Specialty High-Cost Drugs	50%	50%	40%	20%				

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated