2020 PLAN DESIGNS – DEDUCTIBLE & COPAY

MEMBER COST SHARE	High Deductible Health Plan HSA Compatible Plan ID 27248TX0010008	HMO Bronze Deductible 003 Plan ID 27248TX0010003	Community Health Choice HMO Silver Deductible Plans 009 Plan ID 27248TX0010009				Community Health Choice HMO Silver Deductible Plans 004 Plan ID 27248TX0010004				Gold Deductible 005 Plan ID 27248TX0010005	Gold Copay 001 Plan ID 27248TX0010001
			Silver Deductible 009 250% FPL and above	Silver Deductible 009 (73) 200%-249% FPL	Silver Deductible 009 (87) 150%-199% FPL	Silver Deductible 009 (94) 100%-149% FPL	Silver Deductible 004 250% FPL and above	Silver Deductible 004 (73) 200%-249% FPL	Silver Deductible 004 (87) 150%-199% FPL	Silver Deductible 004 (94) 100%-149% FPL		
Medical Deductible (individual/family)	$6,750 / $13,500	$7,150 / $14,300	$5,000 / $10,000	$2,500 / $5,000	N/A	N/A	$3,000 / $6,000	$2,800 / $5,600	N/A	N/A	$750 / $1,500	N/A
Out-of-Pocket Max (individual/family)	$6,750 / $13,500	$8,150 / $16,300	$7,000 / $14,000	$6,000 / $12,000	$2,700 / $5,400	$2,500 / $5,000	$7,900 / $15,800	$6,500 / $13,000	$2,700 / $5,400	$2,500 / $5,000	$6,500 / $13,000	$8,150 / $16,300
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE											
PCP Office Visit	No charge after deductible	*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Specialist Office Visit		*$70	$60	$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Outpatient Facility		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Outpatient Surgery		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Urgent Care Services		*$70	*$60	*$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Ambulance Services		$70	$60	$60	$50	$20	$60	$50	$50	$20	$40	$65
Emergency Room Services		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$700
Inpatient Hospital Care		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Inpatient Skilled Nursing Facility		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Outpatient Mental/Behavioral Substance Abuse		*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Inpatient Mental/Behavioral Substance Abuse		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Outpatient Rehabilitation		$70	$60	$60	$50	$10	$60	$50	$50	$10	$40	$65
Medical Imaging (CT/PET Scans, MRIs)		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$500
Routine Lab/X-Ray/ Diagnostic Imaging		$40	$30	$30	$25	$10	$30	$25	$25	$10	$20	$30
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	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A	Combined with Medical Deductible	N/A
Generic	No charge after deductible	*$15	*$15	*$10	$10	$5	*$10	*$10	$10	$5	*$10	$20
Preferred Brand		$70	$70	$50	$50	$20	$60	$50	$50	$20	$40	$40
Non-Preferred Brand		$120	$120	$100	$85	$40	$100	$90	$85	$40	$70	$80
Specialty High-Cost Drugs		45%	45%	45%	30%	20%	45%	40%	30%	20%	30%	30%

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* 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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DISEÑOS DE PLAN 2020 – DEDUCIBLE Y COPAGOS

PAGO COMPARTIDO DEL MIEMBRO	Plan de Alto Deducible HSA Compatible 008 ID de Plan 27248TX0010008	Plan con Deducibles Bronce 003 ID de Plan 27248TX0010003	Planes con Deducibles Plata de Community Health Choice HMO 009 ID de Plan 27248TX0010009				Planes con Deducibles Plata de Community Health Choice HMO 004 ID de Plan 27248TX0010004				Plan con Deducibles Oro 005 ID de Plan 27248TX0010005	Copago Oro 001 ID de Plan 27248TX0010001
			Plan con Deducibles Plata 009 250% FPL y más	Plan con Deducibles Plata 009 (73) 200%-249% FPL	Plan con Deducibles Plata 009 (87) 150%-199% FPL	Plan con Deducibles Plata 009 (94) 100%-149% FPL	Plan con Deducibles Plata 004 250% FPL y más	Plan con Deducibles Plata 004 (73) 200%-249% FPL	Plan con Deducibles Plata 004 (87) 150%-199% FPL	Plan con Deducibles Plata 004 (94) 100%-149% FPL		
Deducible Médico (individual/ familia)	$6,750 / $13,500	$7,150 / $14,300	$5,000 / $10,000	$2,500 / $5,000	N/A	N/A	$3,000 / $6,000	$2,800 / $5,600	N/A	N/A	$750 / $1,500	N/A
Gasto de su bolsillo máximo (individual/familia)	$6,750 / $13,500	$8,150 / $16,300	$7,000 / $14,000	$6,000 / $12,000	$2,700 / $5,400	$2,500 / $5,000	$7,900 / $15,800	$6,500 / $13,000	$2,700 / $5,400	$2,500 / $5,000	$6,500 / $13,000	$8,150 / $16,300
BENEFICIOS MÉDICOS	COPAGOS Y COSEGUROS DEL MIEMBRO											
Visita a su médico de cabecera (médico de cuidado primario)	no cargo después de deductible	*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Visita al médico especialista		*$70	$60	$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Centro Ambulatorio		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Cirugía Ambulatoria		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$300
Servicios de Cuidado de Urgencias		*$70	*$60	*$60	$50	$20	*$60	*$50	$50	$20	*$40	$65
Servicio de Ambulancia		$70	$60	$60	$50	$20	$60	$50	$50	$20	$40	$65
Servicios de Salas de Emergencia		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$700
Cuidado hospitalario (Cuidados de paciente hospitalizado)		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Centro de enfermería especializada, paciente ingresado		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Salud del Comportamiento/ Mental Ambulatoria		*$40	*$30	*$30	$25	$10	*$30	*$25	$25	$10	*$20	$30
Salud del Comportamiento/ Mental Hospitalaria		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	**$700
Rehabilitación ambulatoria		$70	$60	$60	$50	$10	$60	$50	$50	$10	$40	$65
Imágenes Médicas (TC/ Escaneos PET, Resonancias Magnéticas)		30%	30%	30%	20%	10%	30%	30%	20%	10%	20%	$500
Laboratorio de rutina/rayos X/diagnóstico por imágenes		$40	$30	$30	$25	$10	$30	$25	$25	$10	$20	$30
MEDICAMENTOS CON PRESCRIPCIÓN	COPAGOS Y COSEGUROS DEL MIEMBRO											
Deductible de medicamentos con prescripción (individual/ familia) (Suministro de 90 días por correo, disponible con copago de 2.5)	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	Combinado con el deducuble médico	N/A	N/A	Combinado con el deducuble médico	N/A
Genéricos	no cargo después de deductible	*$15	*$15	*$10	$10	$5	*$10	*$10	$10	$5	*$10	$20
Marcas Preferidas		$70	$70	$50	$50	$20	$60	$50	$50	$20	$40	$40
Marcas no Preferidas		$120	$120	$100	$85	$40	$100	$90	$85	$40	$70	$80
Medicamentos Especializados de Alto Costo		45%	45%	45%	30%	20%	45%	40%	30%	20%	30%	30%

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* Los servicios están exentos de deducible cuando esté indicado (PCP / Especialista / Servicios de Cuidado de Urgencias /Medicamentos Genéricos)
** El copago se aplica por día durante los primeros 5 días
Para los planes con deducibles, los copagos se aplican cuando ha cumplido con su deducible en su totalidad.

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