COMMUNITY 2023 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Bronze

PLANS/VISITS	PREMIER BRONZE 003 PLAN ID 27248TX0010003	PREMIER VIRTUAL BRONZE 11 PLAN ID 27248TX0010011	SELECT BRONZE 016 PLAN ID 27248TX0010016	PREMIER BRONZE 17 PLAN ID 27248TX0010017	PREMIER BRONZE 18 PLAN ID 27248TX0010018
Medical Deductible (individual/family)	$7,700 / $15,400	$9,100 / $18,200	$8,100 / $16,200	$9,100 / $18,200	$7,500 / $15,000
Out-of-Pocket Max (individual/family)	$9,100/$18,200	$9,100 / $18,200	$9,100 / $18,200	$9,100 / $18,200	$9,000 / $18,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE				
PCP Office Visit	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	No charge after deductible	*$50
Specialist Office Visit	$70	No charge after deductible	$90		*$100
Outpatient Facility	40%		50%		50%
Outpatient Surgery	40%		50%		50%
Urgent Care Services	*$70		*$90		*$75
Ambulance Services	$70		$90		$100
Emergency Room Services	40%		50%		50%
Inpatient Hospital Care	40%		50%		50%
Inpatient Skilled Nursing Facility	40%		50%		50%
Outpatient Mental/Behavioral Substance Abuse	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35		*$50
Inpatient Mental/Behavioral Substance Abuse	40%	No charge after deductible	50%		50%
Outpatient Rehabilitation	$70		$90		$100
Medical Imaging (CT/PET Scans, MRIs)	40%		50%		50%
Routine Lab/X-Ray/Diagnostic Imaging	$40		$35		50%
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
Generic	*$16	No charge after deductible	*$30	No charge after deductible	*$25
Preferred Brand	$70		$60	No charge after deductible	$50
Non-Preferred Brand	$120		$130	No charge after deductible	$100
Specialty High-Cost Drugs	45%		50%	No charge after deductible	$500

* 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

COMMUNITY 2023 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Gold

PLANS/VISITS	PREMIER GOLD 001 OFF-EXCHANGE PLAN ID 27248TX0010001	PREMIER GOLD 005 PLAN ID 27248TX0010005	PREMIER GOLD 021 PLAN ID 27248TX0010021	SELECT GOLD 022 PLAN ID 27248TX0010022
Medical Deductible (individual/family)	N/A	$1,600/ $3,200	$2,000/ $4,000	$2,200/ $4,400
Out-of-Pocket Max (individual/family)	$9,100 / $18,200	$9,100 / $18,200	$8,700 / $17,400	$9,100 / $18,200
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	$30	*$20	*$30	*$15
Specialist Office Visit	$65	*$40	*$60	*$30
Outpatient Facility	$300	25%	25%	20%
Outpatient Surgery	$300	25%	25%	20%
Urgent Care Services	$65	*$40	*$45	*$30
Ambulance Services	$65	$40	$60	$30
Emergency Room Services	$800	25%	25%	20%
Inpatient Hospital Care	**$800	25%	25%	20%
Inpatient Skilled Nursing Facility	**$800	25%	25%	20%
Outpatient Mental/Behavioral Substance Abuse	$30	*$20	*$30	*$15
Inpatient Mental/Behavioral Substance Abuse	**$800	25%	25%	20%
Outpatient Rehabilitation	$65	$40	*$30	$30
Medical Imaging (CT/PET Scans, MRIs)	$500	25%	25%	20%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$20	25%	$15
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	$20	*$10	*$15	*$15
Preferred Brand	$40	$50	*$30	$30
Non-Preferred Brand	$80	$75	*$60	$60
Specialty High-Cost Drugs	30%	35%	*$250	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

COMMUNITY 2023 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY PREMIER SILVER 004 PLAN ID 27248TX0010004			
	SILVER 004 251% FPL AND ABOVE	**SILVER 004 (73)** 201%-250% FPL	**SILVER 004 (87)** 151%-200% FPL	**SILVER 004 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$3,300 / $6,600	$3,200 / $6,400	N/A	N/A
Out-of-Pocket Max (individual/family)	$9,100 / $18,200	$7,250 / $14,500	$2,900 / $5,800	$2,000 / $4,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$30	*$30	$25	$10
Specialist Office Visit	*$60	*$60	$50	$20
Outpatient Facility	40%	40%	40%	10%
Outpatient Surgery	40%	40%	40%	10%
Urgent Care Services	*$60	*$60	$50	$20
Ambulance Services	$60	$60	$50	$20
Emergency Room Services	40%	40%	40%	10%
Inpatient Hospital Care	40%	40%	40%	10%
Inpatient Skilled Nursing Facility	40%	40%	40%	10%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	$25	$10
Inpatient Mental/Behavioral Substance Abuse	40%	40%	40%	10%
Outpatient Rehabilitation	$60	$60	$50	$10
Medical Imaging (CT/PET Scans, MRIs)	40%	40%	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	N/A	N/A
Generic	*$10	*$10	$10	$5
Preferred Brand	$70	$60	$50	$20
Non-Preferred Brand	$110	$100	$85	$40
Specialty High-Cost Drugs	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

COMMUNITY 2023 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY PREMIER SILVER 12 PLAN ID 27248TX0010012				COMMUNITY PREMIER SILVER 13 PLAN ID 27248TX0010013			
	SILVER 12 251% FPL AND ABOVE	**SILVER 12 (73)** 201%-250% FPL	**SILVER 12 (87)** 151%-200% FPL	**SILVER 12 (94)** 100%-150% FPL	**SILVER 13** 251% FPL AND ABOVE	**SILVER 13 (73)** 201%-250% FPL	**SILVER 13 (87)** 151%-200% FPL	**SILVER 13 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$3,000 / $6,000	$2,500 / $5,000	$500 / $1,000	N/A	$8,500 / $17,000	$6,800 / $13,600	$2,200 / $4,400	$700 / $1,400
Out-of-Pocket Max (individual/family)	$9,100 / $18,200	$6,950 / $13,900	$2,500 / $5,000	$1,800 / $3,600	$8,500 / $17,000	$6,800 / $13,600	$2,200 / $4,400	$700 / $1,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$25	$10	*$10	*$10	*$10	*$5
Specialist Office Visit	$60	$60	$50	$20	*$20	*$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	*$20	*$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	*$10	*$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

COMMUNITY 2023 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY SELECT SILVER 19 PLAN ID 27248TX0010019				COMMUNITY PREMIER SILVER 20 PLAN ID 27248TX0010020			
	SILVER 19 251% FPL AND ABOVE	**SILVER 19 (73)** 201%-250% FPL	**SILVER 19 (87)** 151%-200% FPL	**SILVER 19 (94)** 100%-150% FPL	**SILVER 20** 251% FPL AND ABOVE	**SILVER 20 (73)** 201%-250% FPL	**SILVER 20 (87)** 151%-200% FPL	**SILVER 20 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$4,900 / $9,800	$3,500 / $7,000	$500 / $1,000	N/A	$5,800 / $11,600	$5,700 / $11,400	$800 / $1,600	N/A
Out-of-Pocket Max (individual/family)	$9,100 / $18,200	$7,250 / $14,500	$3,000 / $6,000	$1,500 / $3,000	$8,900 / $17,800	$7,200 / $14,400	$3,000 / $6,000	$1,700 / $3,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Specialist Office Visit	*$80	*$80	*$40	$25	*$80	*$60	*$40	$10
Outpatient Facility	30%	30%	30%	10%	40%	40%	30%	25%
Outpatient Surgery	30%	30%	30%	10%	40%	40%	30%	25%
Urgent Care Services	*$80	*$80	*$40	$25	*$60	*$45	*$30	$5
Ambulance Services	$80	$80	$40	$25	$80	$60	$40	$10
Emergency Room Services	30%	30%	30%	10%	40%	40%	30%	25%
Inpatient Hospital Care	30%	30%	30%	10%	40%	40%	30%	25%
Inpatient Skilled Nursing Facility	30%	30%	30%	10%	40%	40%	30%	25%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Inpatient Mental/Behavioral Substance Abuse	30%	30%	30%	10%	40%	40%	30%	25%
Outpatient Rehabilitation	$80	$80	$40	$25	*$40	*$30	*$20	$10
Medical Imaging (CT/PET Scans, MRIs)	30%	30%	30%	10%	40%	40%	30%	25%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$20	$5	40%	40%	30%	25%
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	N/A
Generic	*$10	*$10	*$10	$5	*$20	*$20	*$10	$0
Preferred Brand	$40	$40	$25	$15	*$40	*$40	*$20	$15
Non-Preferred Brand	$80	$80	$60	$40	$80	$80	$60	$50
Specialty High-Cost Drugs	50%	50%	50%	30%	$350	$350	$250	$150

* 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