COMMUNITY 2024 PLAN DESIGNS

Bronze

PLANS/VISITS	PREMIER BRONZE 003 PLAN ID 27248TX0010003	PREMIER VIRTUAL BRONZE 11 PLAN ID 27248TX0010011	SELECT BRONZE 016 PLAN ID 27248TX0010016	PREMIER BRONZE 18 PLAN ID 27248TX0010018
Medical Deductible (individual/family)	$7,700 / $15,400	$9,450 / $18,900	$8,100 / $16,200	$7,500 / $15,000
Out-of-Pocket Max (individual/family)	$9,450 / $18,900	$9,450 / $18,900	$9,450 / $18,900	$9,400 / $18,800
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	*$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
Generic	*$16	No charge after deductible	*$30	*$25
Preferred Brand	$70		$60	$50
Non-Preferred Brand	$120		$130	$100
Specialty High-Cost Drugs	45%		50%	$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 2024 PLAN DESIGNS

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	$1,500/ $3,000	$1,800/ $3,600
Out-of-Pocket Max (individual/Family)	$9,450 / $18,900	$9,450 / $18,900	$8,700 / $17,400	$9,450 / $18,900
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	$30	*$20	*$30	*$15
Specialist Office Visit	$65	*$40	*$60	*$30
Outpatient Facility	$300	25%	25%	30%
Outpatient Surgery	$300	25%	25%	30%
Urgent Care Services	$65	*$40	*$45	*$30
Ambulance Services	$65	$40	$60	$30
Emergency Room Services	$800	25%	25%	30%
Inpatient Hospital Care	**$800	25%	25%	30%
Inpatient Skilled Nursing Facility	**$800	25%	25%	30%
Outpatient Mental/Behavioral Substance Abuse	$30	*$20	*$30	*$15
Inpatient Mental/Behavioral Substance Abuse	**$800	25%	25%	30%
Outpatient Rehabilitation	$65	$40	*$30	$30
Medical Imaging (CT/PET Scans, MRIs)	$500	25%	25%	30%
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	$25	*$10	*$15	*$10
Preferred Brand	$40	$50	*$30	*$50
Non-Preferred Brand	$80	$75	*$60	$100
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 2024 PLAN DESIGNS

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)	$9,450 / $18,900	$7,500 / $15,000	$3,000 / $6,000	$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 2024 PLAN DESIGNS

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	$9,100 / $18,200	$7,500 / $15,000	$2,200 / $4,400	$700 / $1,400
Out-of-Pocket Max (individual/Family)	$9,450 / $18,900	$7,100 / $14,200	$2,500 / $5,000	$1,800 / $3,600	$9,100 / $18,200	$7,500 / $15,000	$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 2024 PLAN DESIGNS

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)	$4,500 / $9,000	$3,500 / $7,000	$500 / $1,000	N/A	$5,900 / $11,800	$5,700 / $11,400	$700 / $1,400	N/A
Out-of-Pocket Max (individual/Family)	$9,100 / $18,200	$7,250 / $14,500	$3,000 / $6,000	$1,600 / $3,200	$9,100 / $18,200	$7,200 / $14,400	$3,000 / $6,000	$1,800 / $3,600
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$20	$5	*$40	*$40	*$20	$0
Specialist Office Visit	*$80	*$80	*$40	$25	*$80	*$80	*$40	$10
Outpatient Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Surgery	40%	30%	30%	10%	40%	40%	30%	25%
Urgent Care Services	*$80	*$80	*$40	$25	*$60	*$60	*$30	$5
Ambulance Services	$80	$80	$40	$25	$80	$60	$40	$10
Emergency Room Services	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Hospital Care	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Skilled Nursing Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$20	$5	*$40	*$40	*$20	$0
Inpatient Mental/Behavioral Substance Abuse	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Rehabilitation	$80	$80	$40	$25	*$40	*$30	*$20	$0
Medical Imaging (CT/PET Scans, MRIs)	40%	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	$100	$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.