

# COMMUNITY 2025 PLAN DESIGNS



## Gold

PLANS/VISITS	ULTRA SELECT GOLD 001 OFF-EXCHANGE PLAN ID 11718TX0140001	ULTRA SELECT GOLD 021 PLAN ID 11718TX0140021	ULTRA SELECT GOLD 022 PLAN ID 11718TX0140022
Medical Deductible (individual/Family)	N/A	\$1,500/ \$3,000	\$1,800/ \$3,600
Out-of-Pocket Max (individual/Family)	\$9,200 / \$18,400	\$7,800 / \$15,600	\$9,200 / \$18,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE		
PCP Office Visit	\$30	*\$30	*\$15
Specialist Office Visit	\$65	*\$60	*\$30
Outpatient Facility	\$300	25%	30%
Outpatient Surgery	\$300	25%	30%
Urgent Care Services	\$65	*\$45	*\$30
Ambulance Services	\$65	\$60	\$30
Emergency Room Services	\$800	25%	30%
Inpatient Hospital Care	**\$800	25%	30%
Inpatient Skilled Nursing Facility	**\$800	25%	30%
Outpatient Mental/Behavioral Substance Abuse	\$30	*\$30	*\$15
Inpatient Mental/Behavioral Substance Abuse	**\$800	25%	30%
Outpatient Rehabilitation	\$65	*\$30	\$30
Medical Imaging (CT/PET Scans, MRIs)	\$500	25%	30%
Routine Lab/X-Ray/Diagnostic Imaging	\$30	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
Generic	\$25	*\$15	*\$10
Preferred Brand	\$40	*\$30	*\$50
Non-Preferred Brand	\$80	*\$60	\$100
Specialty High-Cost Drugs	30%	*\$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.