COMMUNITY 2025 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	**COMMUNITY ULTRA SELECT SILVER 19** PLAN ID 11718TX0140019				**COMMUNITY ULTRA SELECT SILVER 20** PLAN ID 11718TX0140020			
	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)	$4,250 / $8,500	$3,200 / $6,400	$500 / $1,000	N/A	$5,000 / $10,000	$3,000 / $6,000	$500 / $1,000	N/A
Out-of-Pocket Max (individual/Family)	$8,500 / $17,000	$7,100 / $14,200	$3,000 / $6,000	$1,600 / $3,200	$8,000 / $16,000	$6,400 / $12,800	$3,000 / $6,000	$2,000 / $4,000
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	$80	$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	*$65	*$65	*$25	$10	*$40	*$40	*$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.