

COMMUNITY 2026 PLAN DESIGNS



Off-Exchange Only

PLANS/VISITS	ULTRA SELECT SILVER 19 PLAN ID 11718TX0140023	ULTRA SELECT SILVER 20 PLAN ID 11718TX0140025	ULTRA SELECT GOLD 001 PLAN ID 11718TX0140001
Medical Deductible (individual/Family)	\$4,500/\$9,000	\$6,000/ \$12,000	N/A
Out-of-Pocket Max (individual/Family)	\$9,000/\$18,000	\$8,900 / \$17,800	\$8,400/\$16,800
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE		
PCP Office Visit	*\$30	*\$40	\$30
Specialist Office Visit	*\$80	*\$80	\$65
Outpatient Facility	40%	40%	\$300
Outpatient Surgery	40%	40%	\$300
Urgent Care Services	*\$80	*\$60	\$65
Ambulance Services	\$80	\$80	\$65
Emergency Room Services	40%	40%	\$500
Inpatient Hospital Care	40%	40%	**\$800
Inpatient Skilled Nursing Facility	40%	40%	**\$800
Outpatient Mental/Behavioral Substance Abuse	*\$30	*\$40	\$30
Inpatient Mental/Behavioral Substance Abuse	40%	40%	**\$800
Outpatient Rehabilitation	*\$65	*\$40	\$65
Medical Imaging (CT/PET Scans, MRIs)	40%	40%	\$500
Routine Lab/X-Ray/Diagnostic Imaging	\$40	40%	\$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	N/A
Generic	*\$15	*\$20	\$25
Preferred Brand	\$45	*\$40	\$40
Non-Preferred Brand	\$100	\$80	\$80
Specialty High-Cost Drugs	50%	\$350	30%

* 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.