

COMMUNITY 2026 PLAN DESIGNS



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)	\$4,500/\$9,000	\$3,500/\$7,000	\$800/\$1,600	N/A	\$6,000/\$12,000	\$3,000 / \$6,000	\$700/\$1,400	N/A
Out-of-Pocket Max (individual/Family)	\$9,000/\$18,000	\$7,500/\$15,000	\$3,000 / \$6,000	\$1,600 / \$3,200	\$8,900/\$17,800	\$7,400/\$14,800	\$3,300/\$6,600	\$2,200/\$4,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*\$30	*\$30	*\$20	\$10	*\$40	*\$40	*\$20	\$0
Specialist Office Visit	*\$80	*\$70	*\$40	\$25	*\$80	*\$80	*\$40	\$10
Outpatient Facility	40%	40%	30%	10%	40%	40%	30%	25%
Outpatient Surgery	40%	40%	30%	10%	40%	40%	30%	25%
Urgent Care Services	*\$80	*\$70	*\$40	\$25	*\$60	*\$60	*\$30	\$5
Ambulance Services	\$80	*\$70	\$40	\$25	\$80	\$80	\$40	\$10
Emergency Room Services	40%	40%	30%	10%	40%	40%	30%	25%
Inpatient Hospital Care	40%	40%	30%	10%	40%	40%	30%	25%
Inpatient Skilled Nursing Facility	40%	40%	30%	10%	40%	40%	30%	25%
Outpatient Mental/Behavioral Substance Abuse	*\$30	*\$30	*\$20	\$10	*\$40	*\$40	*\$20	\$0
Inpatient Mental/Behavioral Substance Abuse	40%	40%	30%	10%	40%	40%	30%	25%
Outpatient Rehabilitation	*\$65	*\$65	*\$25	\$10	*\$40	*\$40	*\$20	\$0
Medical Imaging (CT/PET Scans, MRIs)	40%	40%	30%	10%	40%	40%	30%	25%
Routine Lab/X-Ray/Diagnostic Imaging	\$40	\$40	\$20	\$10	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	*\$15	*\$15	*\$10	\$5	*\$20	*\$20	*\$10	\$0
Preferred Brand	\$45	\$45	\$25	\$15	*\$40	*\$40	*\$20	\$15
Non-Preferred Brand	\$100	\$100	\$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.