COMMUNITY 2026 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Off-Exchange Only

PLANS/VISITS	PREMIER SILVER 12 PLAN ID 27248TX0010024	SELECT SILVER 19 PLAN ID 27248TX0010023/27248TX0010027	PREMIER SILVER 20 PLAN ID 27248TX0010025	PREMIER GOLD 001 PLAN ID 27248TX0010001
Medical Deductible (individual/Family)	$2,800/$5,600	$4,500/$9,000	$6,000/ $12,000	N/A
Out-of-Pocket Max (individual/Family)	$10,600 / $21,200	$9,000/$18,000	$8,900 / $17,800	$8,400/$16,800
MEDICAL BENEFITS	**MEMBER COPAYS/COINSURANCE**			
PCP Office Visit	*$30	*$30	*$40	$30
Specialist Office Visit	$60	*$80	*$80	$65
Outpatient Facility	50%	40%	40%	$300
Outpatient Surgery	50%	40%	40%	$300
Urgent Care Services	*$60	*$80	*$60	$65
Ambulance Services	$60	$80	$80	$65
Emergency Room Services	50%	40%	40%	$500
Inpatient Hospital Care	50%	40%	40%	**$800
Inpatient Skilled Nursing Facility	50%	40%	40%	**$800
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$40	$30
Inpatient Mental/Behavioral Substance Abuse	50%	40%	40%	**$800
Outpatient Rehabilitation	$60	*$65	*$40	$65
Medical Imaging (CT/PET Scans, MRIs)	50%	40%	40%	$500
Routine Lab/X-Ray/Diagnostic Imaging	$30	$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	Combined with Medical Deductible	N/A
Generic	*$10	*$15	*$20	$25
Preferred Brand	$80	$45	*$40	$40
Non-Preferred Brand	$120	$100	$80	$80
Specialty High-Cost Drugs	50%	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.