COMMUNITY FIRST INSURANCE PLANS

SCHEDULE OF BENEFITS AND COST SHARING

University Community Care Plan by Community First – Silver Plan 94

The following chart shows eligible services and supplies for Your Coverage. Please review the Individual Evidence of Coverage for a complete listing of benefits. You must pay all the costs up to the deductible amount (unless plan is a $0 deductible plan) before this plan begins to pay for covered medical services. The Cost Sharing amounts are shown at the right. If there is no Cost Sharing, the service or supply shown will be covered at 100 percent.

In Network Maximum Out of Pocket:
Individual: $1,150
Family: $2,300

In Network Medical Deductible:
Individual: $0
Family: $0

In Network Copayment: (Except for Specialty Drugs as shown below)

Basic Coverage:

Services must be obtained through Participating Network Providers.

Some services may require Preauthorization.

Detailed Prior-Authorization requirements are listed in the Health Insurance Exchange Prior-Authorization List.

Services with a (*) indicate pre-authorization is required.
Services with a (+) indicate pre-authorization may be required.

Out of Pocket Maximums Per Calendar Year Including Pharmacy Benefits	
Per Individual Member	$1,150
Per Family	$2,300
Deductibles Per Calendar Year Including Pharmacy Benefits	
Per Individual Member	$0
Per Family	$0
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$5 copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$10 copay

Inpatient Hospital Services	
*Inpatient Hospital Services, for each admission	$120 copay
Outpatient Facility Services	
Outpatient Surgery- Hospital Setting	$10 copay
Outpatient Surgery- Other Facility Setting	$10 copay
Radiation Therapy	$10 copay
Dialysis	$10 copay
Urgent Care Facility Services	$5 copay
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug - Hospital Setting	$10 copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting	$10 copay
+Non-Maintenance Drug	$10 copay
+Chemotherapy	$100 copay
Outpatient Laboratory and X-Ray Services	
+**Hospital & Other Facility Setting** Computerized Tomography (CT Scan), Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan), SPECT/Nuclear Cardiology studies, per procedure	$10 copay
Other X-Ray Services	$10 copay
+Outpatient Lab (*Genetic Testing Requires Authorization)	$10 copay
Rehabilitation and Habilitation Services	
***Rehabilitation Services, Habilitation Services and Therapies**, per visit: Limited to 35 visits per Calendar Year, including chiropractic services for Rehabilitation Services (+Authorization for Chiropractic not required)	$10 copay unless otherwise covered under Inpatient Hospital Services

Limited to 35 visits per Calendar Year, including chiropractic services for Habilitation Services	
Visit limitations do not apply to Behavioral Health Services Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation and habilitation services visit maximums.	
Maternity Care and Family Planning Services	
Maternity Care Prenatal and Postnatal Visit – After the initial office visit, Subsequent office visits are covered in full Inpatient Hospital Services, for each admission	 $5 copay for PCP $10 copay for Specialist $120 copay
Family Planning Services Diagnostic counseling, consultations and planning services Insertion or removal of intrauterine device (IUD), including cost of device Diaphragm or cervical cap fitting, including cost of device Insertion or removal of birth control device implanted under the skin, including cost of device Injectable contraceptive drugs, including cost of drug	 $5 copay for PCP $10 copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services
Vasectomy	$120 copay for Inpatient Hospital Services; $100 copay for outpatient surgery physician, after any additional charges as described in Outpatient Facility Services may also apply
Infertility Services Diagnostic counseling, consultations, planning and treatment services	 $5 copay for PCP $10 copay for Specialist
Behavioral Health Services	
+Outpatient Mental Health Care	$5 copay for PCP; $10 copay for Outpatient Services.
*Inpatient Mental Health Care	Any charges described in Inpatient Hospital Services will apply.

+Serious Mental Illness	$5 copay for PCP; $10 copay for Outpatient Services.
+Chemical Dependency Services	$5 copay for PCP; $10 copay for Outpatient Services.
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency)	$80 copay; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.)
Urgent Care	
Urgent Care Services	$5 copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Virtual Visits	
Virtual Visits	$5 copay
Ambulance Services	
*Ambulance Services	$10 copay
Extended Care Services	
***Skilled Nursing Facility Services**, for each day, up to 25 days per calendar year	$80 copay
Hospice Care, for each day	$80 copay
***Home Health Care**, per visit, up to 60 visits per Calendar Year	$10 copay
Health Maintenance and Preventive Services	
Well-child care through age 17	No copay
Periodic health assessments for Members age 18 and older	No copay
Immunizations -Childhood immunizations required by law for Members through age 6 -Immunizations for Members over 6	No copay
Bone mass measurement for osteoporosis	No copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No copay
Screening mammogram for female Members age 35 and over, and for female Members with other risk factors, once every twelve months -Outpatient facility or imaging centers	No copay

Contraceptive Services and Supplies -Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices Breastfeeding Support, Counseling and Supplies -Electric breast pumps are limited to one per Calendar Year	No copay
Hearing Loss -Screening test from birth through 30 days -Follow-up care from birth through 24 months	No copay
Rectal screening for the detection of colorectal cancer for Members age 50 and older: -Annual fecal occult blood test, once every twelve months -Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years -Colonoscopy, limited to 1 every 10 years	No copay
Eye and ear screenings for Members through age 17, once every twelve months Eye and ear screening for Members age 18 and older, once every two years Note: Covered children to age 19 do have additional benefits as described in PEDIATRIC VISION CARE BENEFITS	$5 copay for PCP $10 copay for PCP Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply
Early detection test for cardiovascular disease, limited to 1 every 5 years - Computer tomography (CT) scanning - Ultrasonography	$10 copay
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	$5 copay for PCP $10 copay for Specialist Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.

Exam for prostate cancer, once every twelve months	$5 copay for PCP $10 copay for Specialist Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Dental Surgical Procedures	
*Dental Surgical Procedures (limited Covered Services)	$100 copay for outpatient surgery physician; Outpatient Surgery charges as described in Outpatient Facility Services, or: $120 copay for Inpatient Hospital Services
Cosmetic, Reconstructive or Plastic Surgery	
*Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$100 copay for outpatient surgery physician; Outpatient Surgery charges as described in Outpatient Facility Services, or: $120copay for Inpatient Hospital Services
Allergy Care	
Testing and Evaluation Injections Serum	$10 copay
Diabetes Care	
Diabetes Self-Management Training, for each visit	$5 copay for PCP; $10 copay for Specialist
Diabetes Equipment	$10 copay
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable PHARMACY BENEFITS amount shown in the SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS and any applicable pricing differences.	$10 copay
Prosthetic Appliances and Orthotic Devices	
***Prosthetic Appliances and Orthotic Devices**	$10 copay
***Cochlear Implants** Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	$10 copay Any Outpatient Surgery charges described in Outpatient Facility Services may also apply

Durable Medical Equipment	
***Durable Medical Equipment**	$10 copay
Speech and Hearing Services	
+**Speech and Hearing Services** Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech and hearing services visit maximums.	Benefits paid same as any other physical illness
Telehealth and Telemedicine Medical Services	
Telehealth and Telemedicine Medical Services	Benefits paid same as any other office visit
Prescription Drugs	
Generic	$5 copay
Preferred Brand Drugs	$10 copay
Non-preferred brand drugs	$20 copay
+**Specialty Drugs**	20% coinsurance