Plan Description

University Community Care Plan

by Community First Insurance Plans

Welcome to University Community Care Plan (UCCP). UCCP is an insurance plan locally owned and managed by Community First Insurance Plans. Community First was established in 1995 with the unique needs of our community in mind. The information in this document is provided to help you:

- Understand your health care benefits;
- Understand how you can receive health care services from participating Preferred Providers, except as otherwise noted in the contract and written description or as otherwise required by law;
- Learn your rights and responsibilities as a Member of your plan; and,
- Get acquainted with Community First procedures.

Phone Numbers

Community First is here to help you. Our Member Services Department is available Monday through Friday, 8:30 a.m. to 5:00 p.m. CST. Our Member Services representatives speak English and Spanish, or we can get an interpreter to assist you in other languages.

Member Services ..... (210) 358-6400
Toll-free 1-888-512-2347

TDD ..... (210) 358-6080
Toll-free 1-800-390-1175

Community First Nurse Line (NurseLink)

NurseLink (Registered Nurses available 24/7) ..... (210) 358-6400
Toll-free 1-888-512-2347

Corporate Office

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
Monday through Friday, 8:30 a.m. to 5 p.m. CST

Community Outreach Office

Community First Health Plans
1410 Guadalupe Street, Suite 222
San Antonio, Texas 78207
Monday through Friday, 8:30 a.m. to 5 p.m. CST

Website

UniversityCommunityCarePlan.com

Member Handbook

If you need help reading or understanding the UCCP Member Handbook, a Member Services representative will be more than happy to explain any part of the handbook to you. If you need the book in a different format, such as audio, large print, or Braille, please call Member Services.

Preferred Providers

Community First offers an Exclusive Provider Organization (EPO) with only Preferred Providers, except as required by law.

- A **Preferred Provider** is a physician or health care provider, or an organization of physicians or health care providers, who contracts with Community First to provide medical care or health care to insureds covered by a health insurance policy.

- A **Non-Preferred Provider** is a provider who does not have a contract with Community First to provide services to you. You will be responsible for payment if you see a Non-Preferred Provider, except as otherwise noted in the contract and written description or as otherwise required by law.

You may select a primary care physician (PCP) if you choose. A PCP can help you when you need medical advice, when you are sick, and when you need preventive care such as routine physicals and immunizations. You may select a PCP from Community First's extensive network of family or general practitioners, internists, and pediatricians. If you do not select a PCP, you may choose any of our Preferred Providers to coordinate your care.

For a list of Preferred Providers and physicians in the Community First network, visit our website at UniversityCommunityCarePlan.com. You can also call Member Services for assistance.

Benefits, Covered Services, Limitations, and Exclusions

Please consult your individual policy for a list of benefits, covered services, limitations, and exclusions. Certain covered services require authorization prior to receiving services. Failure to obtain prior authorization may result in you being financially responsible for a denied service. If you need help understanding your individual policy or to inquire if a certain service is covered or requires authorization, call Member Services for assistance.

A. Covered Services and Benefits

Covered Services and plan benefits are listed below. Section B ("Limitations and Exclusions") describes any modification of these Covered Services for certain illnesses. A service or supply is not a Covered Service or Supply if excluded. It is excluded to the extent it falls outside any limits described in Section B ("Limitation and Exclusions"). Some Covered Services and Supplies listed in this section may require review for Medical Necessity prior to being rendered.

Covered Services

Inpatient Hospital Services. Services, except Emergency Care and treatment of breast cancer, must be

arranged by your Preferred Provider and preauthorized by Community First. Covered inpatient hospital services include:

1. semi-private room and board, with no limit to number of days unless otherwise indicated;
2. private rooms when Medically Necessary and authorized by your Preferred Provider;
3. special diets and meals when Medically Necessary and authorized by your Preferred Provider;
4. use of intensive care or cardiac care units and related services when Medically Necessary and authorized by your Preferred Provider;
5. use of operating and delivery rooms and related facilities;
6. anesthesia and oxygen services;
7. laboratory, x-ray, and other diagnostic services;
8. drugs, medications, biologicals, and their administration;
9. general nursing care;
10. special duty and private duty nursing when Medically Necessary and authorized by your Preferred Provider;
11. radiation therapy, inhalation therapy, and chemotherapy;
12. blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for you;
13. short-term rehabilitation therapy services in an acute hospital setting;
14. treatment of breast cancer, with no preauthorization required, for a minimum of forty-eight (48) hours following a mastectomy and twenty- four (24) hours following a lymph node dissection; provided, however, that such minimum hours of coverage are not required if you and your attending Provider determine that a shorter period of inpatient care is appropriate. Upon request, the length of stay may be extended if Community First determines that an extension is Medically Necessary; and
15. organ and tissue transplants. Preauthorization is required for any organ or tissue transplant, even if the patient is already under another preauthorization. At the time of preauthorization, Community First will assign a length of stay for the admission. Upon request, the length-of-stay may be extended if the plan determines that an extension is Medically Necessary.

    a. Services, including donor expenses, for organ and tissue transplants are covered, but only if all the following conditions are met:

        (1) the transplant procedure is not experimental/investigational in nature;

        (2) donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used;

        (3) the recipient is a Member;

        (4) the Member meets all of the criteria established by Community First in pertinent written medical policies; and

(5) the Member meets all of the protocols established by the hospital where the transplant is performed.

Covered Services and Supplies related to an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

b. Benefits will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

(1) a recipient who is a Member covered under the plan;

(2) a donor who is a Member covered under the plan; or

(3) a donor who is not a Member covered under the plan.

c. Covered Services and Supplies include those provided for the following:

(1) donor search and acceptability testing of potential live donors;

(2) evaluation of organs or tissues including, but not limited to, the determination of tissue matches;

(3) removal of organs or tissues from living or deceased donors; and

(4) transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Member for the following services and supplies:

(1) living and/or travel expenses of the recipient or a live donor;

(2) expenses related to maintenance of life of a donor for purposes of organ or tissue donation;

(3) purchase of the organ or tissue other than payment for Covered Services and supplies identified above; and

(4) organ or tissue (xenograft) obtained from another species.

Outpatient Facility Services. Services provided through a participating hospital outpatient department or a free-standing facility must be prescribed by your Preferred Provider. Preauthorization may be required for the following services:

1. outpatient surgery;
2. radiation therapy and chemotherapy; and
3. dialysis.

Outpatient Laboratory and X-Ray Services. Laboratory and radiographic procedures, services, and materials, including (but not limited to) diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services must be ordered, authorized, or arranged by your Preferred Provider and provided through a participating facility. Preauthorization may be required.

Community First must reimburse out-of-network diagnostic imaging providers and laboratory service providers when services are performed in connection with a medical or health care service(s) performed by a provider in network. Reimbursement will occur at the usual and customary fee or at the agreed rate. Any out-of-network provider who is a diagnostic imaging provider or laboratory service provider, or a person asserting a claim as an agent or assignee of the provider may not bill an insured individual receiving a medical care or health care service or supply, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's Preferred Provider benefit plan that is:

1. based on:
    a. the amount initially determined payable by the insurer; or
    b. if applicable, the modified amount as determined under the insurer's internal appeal process; and
2. not based on any additional amount determined to be owed to the provider.

Rehabilitation Services. Rehabilitation services and physical, speech, and occupational therapies that, in the opinion of a Provider, are Medically Necessary and meet or exceed your treatment goals are provided when preauthorized or prescribed by your Preferred Provider. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Rehabilitation Services may be provided in the Provider's office, in a hospital as an inpatient, in an outpatient facility, or as home health care visits. Rehabilitation services, including coverage for chiropractic services, are available from a Participating Provider when preauthorized or prescribed by your PCP.

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services, and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care treatment is provided, Community First includes coverage for periodic reevaluation for a Member who: (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. Services may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility, or any other facility where appropriate services or therapies may be provided.

Except for the treatment of Acquired Brain Injury, rehabilitation services are limited as indicated on the Schedule of Benefits and Cost Sharing for your individual plan located at UniversityCommunityCarePlan.com.

Maternity Care Services. Community First provides coverage for inpatient care for the mother and the newborn in a hospital for a minimum of forty-eight (48) hours following an uncomplicated vaginal

delivery or ninety-six (96) hours following an uncomplicated delivery by cesarean section. Preauthorization is not required. Upon request, the length of stay may be extended if Community First determines that an extension is Medically Necessary.

Covered Services, which may require preauthorization, include:

1. prenatal visits;
2. administration of newborn screening test, including the cost of a test kit in the amount required by Health and Safety Code 33.019;
3. use of hospital delivery rooms and related facilities. A separate hospital admission copayment is required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a hospital more than five (5) days after the date of birth, a separate hospital admission copayment for such readmission will be required;
4. use of newborn nursery and related facilities;
5. special procedures as may be Medically Necessary and authorized by the PCP or designated Obstetrician/Gynecologist; and
6. postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, the plan provides coverage for Post-Delivery Care for the mother and newborn. Post- Delivery Care may be provided at the mother's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Preferred Providers if born outside the Service Area due to an emergency or born in an out-of-network facility to a mother who is not a Member. Community First may require the newborn to be transferred to a participating facility at Community First's expense when determined to be medically appropriate by the newborn's treating Provider.

Complications of Pregnancy. Covered Services for Complications of Pregnancy will be the same as for treatment of any other physical illness and may require preauthorization. Complications of pregnancy include:

1. conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Family Planning. Covered Services, which may require preauthorization, include:

1. diagnostic counseling, consultations, and planning services for family planning;

2. insertion or removal of an intrauterine device (IUD), including the cost of the device;

3. diaphragm or cervical cap fitting, including the cost of the device;

4. insertion or removal of birth control device implanted under the skin, including the cost of the device;

5. injectable contraceptive drugs, including the cost of the drug; and

6. voluntary sterilizations, including vasectomy and tubal ligation.

Note: Some benefits for family planning are available under **Health Maintenance and Preventive Services.**

Infertility Services. Covered Services, which may require preauthorization, include diagnostic counseling, consultations, planning services, and treatment for fertility and infertility problems, subject to the exclusions in Section B ("Limitations and Exclusions"). Once the infertility workup and testing have been completed, subsequent workups and testing will require approval of a Community First Medical Director.

Behavioral Health Services

Outpatient Mental Health Care. Covered Services include diagnostic evaluation and treatment or crisis intervention when authorized by Community First.

Inpatient Mental Health Care. Covered Services include inpatient Mental Health Care when authorized by Community First. Covered Services must be rendered based on an individual treatment plan with specific, attainable goals and objectives appropriate to both the patient and the treatment modality of the program. Services in a Residential Treatment Center for Children and Adolescents, a Residential Treatment Center, or a Crisis Stabilization Unit are available only when the Member has an acute condition that substantially impairs thought, perception of reality, emotional process or judgment, or grossly impairs behavior as manifested by recent disturbing behavior, which would otherwise necessitate confinement in a Participating Mental Health Treatment Facility.

Serious Mental Illness. Covered Services include treatment of Serious Mental Illness when authorized by Community First or its designated behavioral health administrator and rendered by a Preferred Provider. Services are subject to the same limitations as any other **Behavioral Health Services**.

Chemical Dependency Services. Treatment of Chemical Dependency is the same as the treatment of any other **Behavioral Health Service,** but is restricted as described in Section B ("Limitations and Exclusions")**.** Inpatient treatment for Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Some services may require preauthorization by Community First.

Emergency Services

Community First will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility that is necessary to determine whether

an emergency medical condition exists.

Emergency Care. Emergency Care Services, whether rendered by Preferred or non-Preferred Providers and/or received within or outside the Service Area, will be covered based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel. Emergency Care services are subject to copayment unless you are admitted as an inpatient directly from the emergency room, in which case you pay the inpatient hospital copayment and any amounts due.

If post-stabilization care is required after an Emergency Care condition has been treated and stabilized, the treating Provider will contact Community First, who must approve or deny coverage of the post-stabilization care requested within one (1) hour of receiving the call.

Notwithstanding anything in this policy to the contrary, for Emergency Care rendered by Providers who are not part of Community First's network of Preferred Providers (non-Preferred Providers) or otherwise contracted with the EPO, the Allowable Amount shall be equal to the greatest of the following possible amounts—not to exceed billed charges:

1. the median amount negotiated with Preferred Providers for emergency services furnished; or
2. the amount for the Emergency Care service calculated using the same method Community First generally uses to determine payments for non-Preferred Provider services by substituting the Preferred Providers cost-sharing provisions for the non-Preferred Providers cost-sharing provisions;
3. the amount that would be paid under Medicare for the Emergency Care;
4. the agreed rate, or usual and customary rate.

Each of these amounts is calculated excluding any in-network copayment/imposed with respect to the Member.

You may receive Emergency Care services in an Urgent Care center.

Out-of-Area Emergency Services. Only Emergency Care services as described above are covered. Continuing or follow-up treatment for accidental injury or Emergency Care is limited to care required before you can return to the Service Area without medically harmful or injurious consequences.

Urgent Care Services. Urgent Care services are covered when rendered by an in-network Urgent Care Provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require Emergency Care services. Additional charges described in Outpatient Laboratory and X-ray Services or Outpatient Facility Services may also apply.

Unless designated and recognized by Community First as an in-network Urgent Care center, neither a hospital nor an emergency room will be considered an Urgent Care center.

Ambulance Services. Professional local ground ambulance service or air ambulance service to the nearest hospital is covered when authorized by the PCP or for Emergency Care, as defined in this policy. When use of air ambulance is being considered, and circumstances permit, Community First must approve prior to use.
Emergency ambulance service is covered when the ambulance is ordered by an employer, school, or public safety official or when you are not in a position to refuse the service.

Extended Care Services. Covered Services include the following when prescribed by your Preferred Provider and authorized by Community First. Services may have additional limitations as indicated on the Schedule of Benefits and Cost Sharing for your individual plan at UniversityCommunityCarePlan.com and restrictions or exclusions described in "Limitations and Exclusions" (Section B).

Skilled Nursing Facility Services. Services must be temporary and lead to rehabilitation and an increased ability to function. Custodial Care is not covered. If you remain in a Skilled Nursing Facility after your Preferred Provider discharges you or after you reach the maximum benefit period or period authorized by Community First, you will be liable for all subsequent costs incurred.

Hospice Care. Care provided by a hospital, Skilled Nursing Facility, hospice, or a duly licensed Hospice Care agency, is approved by Community First and is focused on palliative rather than curative treatment for Members with a medical condition and a prognosis of terminal illness. Services include bereavement counseling.

Home Health Care. Care in the home by Health Care Professionals who are Preferred Providers, including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists or home health aides. Services must be provided or arranged by your Preferred Provider.

Health Maintenance and Preventive Services. Covered Services, which may require preauthorization and will not be subject to any copayment, include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law:

1. well childcare for Members through age seventeen (17), which includes evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;

2. periodic health assessments for Members eighteen (18) and older, based on age, sex, and medical history;

3. routine immunizations recommended by the American Academy of Pediatrics, U.S. Public Health Service for people in the United States and required by law, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization required by the law for a child. (Allergy injections are not considered immunizations under this benefit

provision.);

4. a physical exam and an annual prostate-specific antigen (PSA) test (once every 12 months) for the detection of prostate cancer for male Members who are at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor;

5. bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals, including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

6. preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well-woman gynecological exam (once every 12 months) for female Members and a medically recognized diagnostic exam for the early detection of cervical cancer for female Members age eighteen (18) and older. Your Preferred Provider or any Obstetrician/Gynecologist in the Plan's network of Preferred Providers may perform the well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid-based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. For help in selecting an Obstetrician/Gynecologist, refer to the Community First EPO Provider Directory, contact your Preferred Provider, or call Member Services;

7. a screening (non-diagnostic) mammogram (once every 12 months) to detect breast cancer for female Members over the age of thirty-five (35) and for female Members with other risk factors. Mammograms may be obtained whether or not a well-woman exam is performed at the same time;

8. preventive care and screenings provided with respect to women's services will be provided for the following Covered Services and will not be subject to a copayment:

   Contraceptive Services and Supplies. Benefits are available for female sterilization procedures and Outpatient Contraceptive Services for women of reproductive capacity. Outpatient Contraceptive Services include a consultation, examination, procedure, or medical service related to the use of a drug or device intended to prevent pregnancy.

   Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA-approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives and vaginal contraceptive devices. NOTE: Prescription contraceptive medications are covered under Pharmacy Benefits.

   To determine if a specific drug or device is available under this Preventive Services

benefit, contact Member Services at the toll-free number on the back of your identification card. This list may change as FDA guidelines, medical management, and medical policies are modified. Benefits will also be provided to women with reproductive capacity for FDA-approved over-the-counter contraceptives for women with a written prescription by a Preferred Provider. You will be required to pay the full amount and submit a reimbursement claim form along with the written prescription to Community First with itemized receipts. Visit UniversityCommunityCarePlan.com to obtain a claim form.

1. a screening test for hearing loss for Members from birth through age thirty (30) days, and necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months; and

2. a medically recognized diagnostic rectal screening exam for the detection of colorectal cancer for Members age fifty (50) or older. Covered Services include, but are not limited to, a fecal occult blood test once every twelve (12) months, a flexible sigmoidoscopy with hemoccult of the stool every five (5) years, and a colonoscopy every ten (10) years.

3. Colorectal cancer testing, exams, preventive services, and lab tests with an "A" or "B" grade from the USPSTF starting at age 45 must be covered. If tests, colonoscopy, or procedure results are abnormal, a follow-up colonoscopy is covered.

4. Any test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. This includes expanded minimum coverage requirements for certain tests of papillomavirus, ovarian cancer, and cervical cancer.

Examples of other covered preventive services that are not subject to copayment include smoking cessation counseling services, health diet counseling, and obesity screening/counseling.

The covered preventive services described above may change as the USPSTF, CDC, and/or HRSA guidelines and state laws are modified.

If a recommendation or guideline for a particular preventive service does not specify the frequency, method, treatment, or setting in which it must be provided, Community First may use reasonable medical management techniques to determine benefits. For more information, contact Member Services at the toll-free number on your identification card.

If a covered preventive service is provided during an office visit and is billed separately from the office visit, you may be responsible for copayment for the office visit only. If an office visit and the preventive health service are not billed separately, and the primary purpose of the visit was not the preventive health service, you may be responsible for copayment for the office visit, including the preventive health service.

Additional preventive screening services, which may require preauthorization and may be subject to copayment, include:

1. eye and ear screenings (once every 12 months) performed or authorized by your Preferred Provider for Members through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in the Preferred Provider's office and do not include refractions;

2. eye and ear screenings (once every two years) performed or authorized by your Preferred Provider for Members eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in the Preferred Provider's office and do not include refractions;

   Note: Covered children to age 19 have additional benefits.

3. early detection test for cardiovascular disease. Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years when performed by a laboratory that is certified by a recognized national organization:

   a. computed tomography (CT) scanning measuring coronary artery calcifications; or

   b. ultrasonography measuring carotid intima-media thickness and plaque.

   Tests are available to each covered Member who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The Member must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

   Benefits are limited as indicated on the Schedule of Benefits and Cost Sharing for your individual plan located at UniversityCommunityCarePlan.com.

Dental Surgical Procedures. General dental services are not covered, but limited oral surgical procedures are covered when prescribed by your Preferred Provider and performed in a Preferred Provider's office

or in a participating inpatient or outpatient setting.

The following Covered Services may require preauthorization by Community First:

1. treatment for accidental injury to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing, when treatment is completed within twenty-four (24) months of the initial treatment. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;

2. treatment or correction of a non-dental physiological condition that has resulted in severe functional impairment;

3. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;

4. diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology; and

5. removal of complete bony impacted teeth.

Cosmetic, Reconstructive, or Plastic Surgery. Coverage will generally be the same as for treatment of any other physical illness, only when prescribed or arranged by your Preferred Provider, and may require preauthorization by Community First. Covered Services are limited to the following:

1. surgery to correct a defect resulting from accidental injury ;

2. surgery to correct a functional defect that results from a congenital and/or acquired disease or anomaly;

3. surgical reconstruction of the breast following a mastectomy and surgical reconstruction of the other breast to achieve a symmetrical appearance; and

4. Reconstructive Surgery for Craniofacial Abnormalities for a Member under age nineteen (19)

Allergy Care. Covered Services for testing and treatment must be provided or arranged by your Preferred Provider.

Diabetes Care

Diabetes Self-Management Training. Covered Services, which may require preauthorization, include instructions enabling a person with diabetes and/or his caretaker to understand the care and management of diabetes; development of an individualized management plan; nutritional counseling, and proper use of diabetes equipment and supplies. Diabetes self-management training is provided on the following occasions:

1. The initial diagnosis of diabetes;

2. a significant change in symptoms or condition that requires changes in your self-management regime, as diagnosed by a Preferred Provider or practitioner;
3. the prescription of periodic or episodic continuing education warranted by the development of new techniques and treatments for diabetes; or
4. the need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

Diabetes Equipment and Supplies. Diabetes equipment and supplies are covered for Members diagnosed with insulin-dependent or non-insulin-dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels.

When the diabetes equipment and supplies in the list below are obtained, you may be required to pay the full amount of their bill and submit a reimbursement claim form to Community First with itemized receipts.

Diabetes equipment and supplies include, but are not limited to:

- blood glucose monitors
- noninvasive glucose monitors and monitors for the blind
- insulin pumps and necessary accessories
- insulin infusion devices
- disposable biohazard containers
- podiatric appliances (including up to two pairs of therapeutic footwear per calendar year)

Visit UniversityCommunityCarePlan.com to obtain a medical claim form. If you choose to purchase diabetes supplies utilizing pharmacy benefits, you must pay the applicable pharmacy benefits copayment in the Schedule of Benefits and Cost Sharing for your individual plan located UniversityCommunityCarePlan.com and any applicable pricing differences. No claim forms are required.

The diabetes equipment and supplies in the list below are only available utilizing pharmacy benefits.

- glucose meter solution
- test strips specified for use with a corresponding blood glucose monitor
- visual reading and urine test strips and tablets that test for glucose, ketones, and protein
- lancets and lancet devices
- injection aids, including devices used to assist with insulin injection and needleless

systems

- glucagon emergency kits
- prescription orders for insulin and insulin analog preparations
- insulin syringes
- prescriptive and nonprescriptive oral agents for controlling blood sugar levels

When you purchase these items with your pharmacy benefits, you must pay the applicable pharmacy benefits copayment in the Schedule of Benefits and Cost Sharing for your individual plan located at UniversityCommunityCarePlan.com and any applicable pricing differences. No claim forms are required.

Prosthetic Appliances and Orthotic Devices. The following covered appliances and devices must be provided or arranged by the Preferred Provider and may require preauthorization by Community First.

1. Initial Prosthetic Appliances are covered subject to restrictions in the Schedule of Benefits and Cost Sharing for your individual plan located at UniversityCommunityCarePlan.com and "Limitations and Exclusions" (Section B).
2. Repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by you.
3. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg, or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets; and Provider prescribed, directed, or applied dressings, bandages, trusses, and splints that are custom designed to assist the function of a joint.
4. Initial breast prostheses and two surgical brassieres after mastectomy.

Durable Medical Equipment (DME). You must obtain services and devices through a Participating DME Provider, which must be consistent with the Medicare DME Manual (guides exchange products), and may require preauthorization by Community First. The plan will determine whether DME is rented or purchased and retains the option to recover the DME upon cancellation or termination of your coverage.

Examples of DME are standard wheelchairs, crutches, walkers, orthopedic tractions, hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in "Limitations and Exclusions" (Section B).

Hearing Aids. Covered Services and equipment, which may require preauthorization, include one audiometric examination to determine the type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing aid device(s). Exclusions are listed in "Limitations and Exclusions" (Section B).

Speech and Hearing Services. Covered Services, which may require preauthorization, include inpatient and outpatient care and treatment for loss or impairment of speech or hearing that is not less favorable than for

physical illness generally. Medically necessary hearing aids or cochlear implants and related services and supplies are covered for individuals 18 years or younger. This includes fitting and dispensing services, treatment for habilitation and rehabilitation, and (for cochlear implant) an external speech processor and controller with necessary components and replacement every three years.

Autism Spectrum Disorder. Generally recognized services prescribed in relation to Autism Spectrum Disorder by your Preferred Provider in a treatment plan recommended by that Provider are covered. No benefit maximums will apply.

Individuals providing treatment prescribed under that plan must be:

1. a health care practitioner
    a. who is licensed, certified, or registered by an appropriate agency of the state of Texas;
    b. whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    c. who is certified as a Provider under the TRICARE military health system.
2. an individual acting under the supervision of a health care practitioner described in item 1. Treatment may include services such as:
    a. evaluation and assessment services;
    b. screening at 18 and 24 months;
    c. applied behavior analysis;
    d. behavior training and behavior management;
    e. speech therapy;
    f. occupational therapy;
    g. physical therapy; or
    h. medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

All standard contractual provisions of this policy will apply, including but not limited to defined terms, limitations, and exclusions.

Routine Patient Costs for Participants in Certain Clinical Trials. Covered Services for Routine Patient Care Costs, as defined in your plan policy, are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

Any of the following federally funded or approved trials:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health (NIH);

- Centers for Medicare and Medicaid Services;
- Agency for Healthcare Research and Quality;
- A cooperative group or center of any of the previous entities;
- the United States Food and Drug Administration;
- the United States Department of Defense (DOD);
- the United States Department of Veterans Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA, or Department of Energy if the study has been reviewed and approved through a peer review system; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Services are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial. Services must be provided or arranged by the PCP.

B. Limitations and Exclusions

There are not out of area services and benefits. The EPO network only provides services in Bexar County. It is important to note that Emergency Services are covered out of network at the same rate as in network.

The insured will be required to pay copayments for out-of-network services that Community First is required to cover by law (Emergency Room, Diagnostic Imaging, and Laboratory performed in connection with services ordered or provided by an in-network provider). All other services the insured utilizes outside of the EPO network will be at the insured's cost.

The following benefits are not covered unless specifically outlined in Covered Services and Benefits (Section A) or Pharmacy Benefits.

1. Services or supplies of non-Preferred Providers, except:
    a. Emergency Care;
    b. when authorized by Community First or your Provider; and
    c. female Members may directly access an Obstetrician/Gynecologist for:
        (1) well-woman exams;
        (2) obstetrical care;
        (3) care for all active gynecological conditions; and

(4) diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

2. Services or supplies which, in the judgment of your Preferred Provider or Community First, are not Medically Necessary and essential to the diagnosis or direct care and

   treatment of a sickness, injury, condition, disease, or bodily malfunction as defined herein. Denials based on non-medical services are adverse determinations and subject to the utilization review processes, including reviews by independent review organizations.

3. If a service is not covered, Community First will not cover any services related to it. Related services are:

   a. services in preparation for the non-covered service;

   b. services in connection with providing the non-covered service;

   c. hospitalization required to perform the non-covered service; or

   d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

4. Experimental/Investigational services and supplies. Denials based on experimental/investigational services are adverse determinations and subject to the utilization review processes, including reviews by independent review organizations.

5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for the acquisition of medical records.

6. Special medical reports not directly related to treatment.

7. Examinations, testing, vaccinations, or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties, or for personal travel.

8. Services or supplies provided by a person who is related to a Member by blood or marriage and self-administered services.

9. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war, or while on active or reserve duty in the armed forces of any country or international authority.

10. Benefits for which you are eligible through Medicare Part B.

11. Care for conditions that federal, state, or local law requires to be treated in a public facility.

12. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.

13. Services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

14. Any services and supplies provided to a Member incurred outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs.

15. Transportation services except as described in **Ambulance Services** or when approved by Community First.

16. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, and maternity kits provided by a hospital or other inpatient facility.

17. Private rooms unless Medically Necessary and authorized by Community First. If a semi-private room is unavailable, the plan covers a private room until a semi-private room is available.

18. Any and all transplants of organs, cells, and other tissues, except as described in **Inpatient Hospital Services**. Services or supplies related to organ and tissue transplant or other procedures when you are the donor and the recipient is not a Member are not covered.

19. Services or supplies for Custodial Care.

20. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged, or any similar institution.

21. Private duty nursing, except when determined to be Medically Necessary and ordered or authorized by your Preferred Provider.

22. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:

    a. an inpatient nutritional assessment program provided in and by a hospital and approved by Community First;

    b. dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;

    c. as described in **Diabetes Care**;

    d. as described in **Autism Spectrum Disorder.**

23. Services or supplies for Cosmetic, Reconstructive, or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive, or Plastic Surgery**.

24. Services or supplies provided primarily for:

    a. Environmental Sensitivity; or

    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists;

    c. inpatient allergy testing or treatment.

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.

    a. sterilization reversal (male or female);

    b. transsexual surgery and related treatment, including hormone therapy and medical or psychological counseling;

    c. treatment of sexual dysfunction, including medications, penile prostheses, and other

surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;

d. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination superovulation uterine capacitation enhancement, direct- intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer and tubal embryo transfer;

e. any services or supplies related to in vitro fertilization or other procedures when you are the donor and the recipient is not a Member;

f. in vitro fertilization and fertility drugs.

26. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

27. Services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Member has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.

28. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

29. Services or supplies for dental care, except as described in **Dental Surgical Procedures**.

30. Non-surgical or non-diagnostic services or supplies for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves. Medically Necessary diagnostic and/or surgical treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, trauma, congenital defect, developmental defect, or pathology, as described in **Dental Surgical Procedures**, **item 4.**

31. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy, and aroma therapy.

32. Services or supplies for:

a. intersegmental traction;

b. surface EMGs;

c. spinal manipulation under anesthesia;

d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron.

33. Galvanic stimulators or TENS units.

34. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings, bandages, garter belts, ostomy bags.

35. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** including, but not limited to:

    a. orthodontic or other dental appliances or dentures;

    b. splints or bandages provided by a Provider in a non-hospital setting or purchased over-the-counter for the support of strains and sprains;

    c. corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made, or built-up shoes and cast shoes; shoe inserts designed to support the arch or effect changes in the foot or foot alignment; arch supports, orthotics, braces, splints, or other foot care items.

36. Psychological/neuropsychological testing and psychotherapy services including, but not limited to:

    a. educational testing;

    b. employer/government mandated testing;

    c. testing to determine eligibility for disability benefits;

    d. testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court-mandated testing;

    e. testing for vocational purposes (e.g., interest inventories, work-related inventories, and career development);

    f. services directed at enhancing one's personality or lifestyle;

    g. vocational or religious counseling;

    h. activities primarily of an educational nature;

    i. music or dance therapy;

    j. bioenergetic therapy; or psychotherapeutic services accessed concurrently by more than one Mental Healthcare Provider.

37. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

38. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder.**

39. Residential Treatment Centers for Chemical Dependency that are not:

    a. affiliated with a hospital under a contractual agreement with an established system for patient Referral;

    b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;

    c. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

    d. licensed, certified, or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

40. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.

41. Replacement for loss, damage, or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).

42. Deluxe equipment such as motor-driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bed boards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement, repairs or maintenance of the DME.

43. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:

    a. as provided while confined as an inpatient,

    b. as provided under **Autism Spectrum Disorder**;

    c. as provided under **Diabetes Care**;

    d. contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Preferred Provider; or

    e. if covered under **Pharmacy Benefits.**

44. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Preferred Provider.

C. Authorization Requirements

Services with a (*) indicate preauthorization is required.

Services with a (+) indicate preauthorization may be required.

Out-of-Pocket Maximums Per Calendar Year Including Pharmacy Benefits	
Per Individual Member	See Individual Plan
Per Family	See Individual Plan
Deductibles Per Calendar Year Including Pharmacy Benefits	
Per Individual Member	$0
Per Family	$0
Professional Services	
Preferred Provider Office or Home Visit	Copay (See Individual Plan)
Participating Specialist Physician ("Specialist") Office or Home Visit	Copay (See Individual Plan)
Inpatient Hospital Services	
*Inpatient Hospital Services, for each admission	Copay (See Individual Plan)
Outpatient Facility Services	
Outpatient Surgery- Hospital Setting	Copay (See Individual Plan)
Outpatient Surgery- Other Facility Setting	Copay (See Individual Plan)
Radiation Therapy	Copay (See Individual Plan)
Dialysis	Copay (See Individual Plan)
Urgent Care Facility Services	Copay (See Individual Plan)
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug - Hospital Setting	Copay (See Individual Plan)
+Routine Maintenance Drug - Home, Office, Infusion Suite Setting	Copay (See Individual Plan)
+Non-Maintenance Drug	Copay (See Individual Plan)

+Chemotherapy	Copay (See Individual Plan)
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	Copay (See Individual Plan)
Other X-Ray Services	Copay (See Individual Plan)
+Outpatient Lab (*Genetic Testing Requires Authorization)	Copay (See Individual Plan)
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) Limited to 35 visits per Calendar Year, including chiropractic services for Habilitation Services Visit limitations do not apply to Behavioral Health Services or the treatment of an Acquired Brain Injury. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation and habilitation services visit maximums.	Copay unless otherwise covered under Inpatient Hospital Services (See Individual Plan)
Maternity Care and Family Planning Services	

Maternity Care	
Prenatal and Postnatal Visit – After the initial office visit, subsequent office visits are covered in full	Copay for Preferred Provider (See Individual Plan) Copay for Specialist (See Individual Plan)
Inpatient Hospital Services, for each admission	Copay (See Individual Plan)
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	Copay for Preferred Provider (See Individual Plan) Copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services (See Individual Plan)
Vasectomy	Copay for Inpatient Hospital Services (See Individual Plan); Copay for outpatient surgery physician, after any additional charges as described in Outpatient Facility Services, may also apply (See Individual Plan)
Infertility Services	
Diagnostic counseling, consultations, planning, and treatment services	Copay for Preferred Provider (See Individual Plan) Copay for Specialist (See Individual Plan)
Behavioral Health Services	
+Outpatient Mental Health Care	Copay for Preferred Provider; Copay for Outpatient Services (See Individual Plan)
*Inpatient Mental Health Care	Any charges described in Inpatient Hospital Services will apply.
+Serious Mental Illness	Copay for Preferred Provider; Copay for Outpatient Services (See Individual Plan)
+Chemical Dependency Services	Copay for Preferred Provider; Copay for Outpatient Services (See Individual Plan).

Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency)	Copay; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.) (See Individual Plan)
Urgent Care	
Urgent Care Services	Copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply. (See Individual Plan)
Virtual Visits	
Virtual Visits	Copay (See Individual Plan)
Ambulance Services	
*Ambulance Services	Copay (See Individual Plan)
Extended Care Services	
*Skilled Nursing Facility Services, for each day, up to 25 days per calendar year	Copay (See Individual Plan)
Hospice Care, for each day	Copay (See Individual Plan)
*Home Health Care, per visit, up to 60 visits per Calendar Year	Copay (See Individual Plan)
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 12 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 12 months Flexible sigmoidoscopy with hemoccult of the stool, limited to one every 5 years Colonoscopy, limited to one 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 have additional benefits	Copay for Preferred Provider (See Individual Plan) Copay for Preferred Provider (See Individual Plan) Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply
Early detection test for cardiovascular disease, limited to one every 5 years Computer tomography (CT) scanning Ultrasonography	Copay (See Individual Plan)

Early detection test for ovarian cancer (CA125 blood test) once every 12 months	Copay for Preferred Provider (See Individual Plan) Copay for Specialist (See Individual Plan) Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Exam for prostate cancer once every 12 months	Copay for Preferred Provider (See Individual Plan) Copay for Specialist (See Individual Plan) Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Dental Surgical Procedures	
*Dental Surgical Procedures (Limited Covered Services)	Copay for outpatient surgery physician; Outpatient Surgery charges as described in Outpatient Facility Services, or (See Individual Plan): Copay for Inpatient Hospital Services (See Individual Plan)
Cosmetic, Reconstructive, or Plastic Surgery	
*Cosmetic, Reconstructive, or Plastic Surgery (Limited Covered Services)	Copay for outpatient surgery physician; Outpatient Surgery charges as described in Outpatient Facility Services, or (See Individual Plan): Copay for Inpatient Hospital Services (See Individual Plan)
Allergy Care	
Testing and Evaluation Injections Serum	Copay (See Individual Plan)
Diabetes Care	
Diabetes Self-Management Training, for each visit	Copay for Preferred Provider; Copay for Specialist (See Individual Plan)
Diabetes Equipment	Copay (See Individual Plan)

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 Benefits and Cost Sharing for your individual plan located at UniversityCommunityCarePlan.com and any applicable pricing differences.	Copay (See Individual Plan)
Prosthetic Appliances and Orthotic Devices	
*Prosthetic Appliances and Orthotic Devices	Copay (See Individual Plan)
*Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	Copay (See Individual Plan) Any Outpatient Surgery charges described in Outpatient Facility Services may also apply
Durable Medical Equipment	
*Durable Medical Equipment	Copay (See Individual Plan)
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	Copay (See Individual Plan)
Preferred Brand Drugs	Copay (See Individual Plan)
Non-preferred brand drugs	Copay (See Individual Plan)
+Specialty Drugs	Coinsurance (See Individual Plan)

D. Payment for Services/Claims

When you receive medical treatment from a Community First Preferred provider, there are no claim forms to complete and no bills to submit. You are responsible for your copayment(s) and/or other costs at the time services are rendered. You should not get a bill from Community First Preferred providers for covered services. If you believe you received a bill in error, call Member Services at (210) 358-6400 or toll-free, (888) 512-2347 for assistance.

If you choose to receive medical treatment from a non-Preferred Provider or at a non-participating facility, or you receive non-emergency treatment in an emergency room without authorization from Community First, you will be responsible for the bills.

Once in a while, you may receive a bill for laboratory work or another service that should have been sent to Community First. If this happens, call Member Services at (210) 358-6400 or toll-free at 1-888-512-2347, and a representative will assist you.

Call Member Services at (210) 358-6400 or toll-free at 1-888-512-2347 if you have paid for services that you believe should be reimbursed or if you believe you received a bill in error for covered services.

E. Types of Care

After Hours Care. Illnesses and injuries sometimes occur after regular office hours. If you get sick or injured after hours, you should call your Preferred Provider. You can also call the Community First Nurse Line. We have Registered Nurses who can help you 24 hours a day, seven days a week. The nurse may refer you to an urgent care center, the hospital emergency room, or to a doctor who is open after regular office hours. The nurse might also give you advice for at-home care.

Urgent Care. An urgent care situation is not as serious as an emergency but requires treatment within 24 hours. If you have an urgent illness or injury that is severe or painful enough to require assessment and/or treatment within 24 hours, you should contact your Preferred Provider, who will direct you based on your symptoms. If you are within the Community First Health Plan service area and cannot reach your Preferred Provider, you may call Member Services. The Community First Nurse Line is available after hours and on the weekend and is staffed with Registered Nurses who can help you locate an urgent care facility if needed. Please call (210) 358-6400 or toll-free at 1-888-512-2347 for assistance locating an urgent care facility.

Emergency Care. Emergency care includes those health care services you receive in a hospital emergency room or comparable facility to evaluate and stabilize medical conditions, including behavioral health conditions. These conditions are of recent onset and severity (such as severe pain) that require immediate attention. Services for emergency care are covered anywhere in the world, 24 hours a day. If an emergency occurs, you should call 911 or go to the nearest medical facility.

Necessary emergency care services will be provided to you, including treatment and stabilization of a medical condition and any medical screening examination or other evaluation required by state or federal law that is necessary to determine if an emergency exists.

If, after medical screening, emergency treatment is determined not to be necessary, contact your Preferred Provider to arrange any non-emergency care needed. If you choose to use the emergency room for non-emergency treatment, you will be responsible for all billed charges.

If you have any questions regarding whether a situation is an emergency, please contact your Preferred Provider, who will direct you based on your symptoms. Additionally, you may call the Community First

Nurse Line, which offers medical advice from a Registered Nurse 24 hours a day, seven days a week at (210) 358-6400 or toll-free at 1-888-512-2347. Our Nurse Line also provides preauthorization for urgent care and emergency care services during non-business hours.

Contact your Preferred Provider before receiving follow-up care, even if you are referred to a specialty care physician from the emergency room or advised to return to the emergency room by the treating physician.

If You Are Away From Home. Only emergency care services are covered outside the Community First's network and/or service area unless medically necessary covered services are not available through Community First's network of Preferred Providers or in the case of court-ordered dependent coverage. In a life or limb-threatening emergency, go to the nearest emergency room.

F. Prescription Drugs

Community First maintains a Preferred Drug List (PDL) that tells you which medications are generic, preferred, and non-preferred. A copy of the current PDL can be obtained by calling Member Services. A representative can also answer questions about your prescription drug benefits. The PDL is also posted on the University Community Care Plan website at UniversityCommunityCarePlan.com.

Your pharmacy benefit consists of three tiers. Generally, the first tier includes generic drugs, the second tier includes preferred brand name drugs, and the third tier includes non-preferred brand name drugs. Copayments vary based on the tier (the higher the tier, the higher your copayment) and whether or not the drug is a maintenance or non-maintenance drug. Maintenance drugs are those that you take on an ongoing basis. With the exception of tier 1 drugs, maintenance drugs have higher copays. The Community First PDL denotes maintenance drugs with an asterisk (*). Check your individual policy and your Drug Rider for information about drug copayments included in this packet, or find this information online at UniversityCommunityCarePlan.com.

G. Benefits, Covered Services, Limitations, and Exclusions

Please consult your individual policy for a listing of benefits, covered services, limitations, and exclusions. Certain covered services require authorization prior to receiving services. Failure to obtain prior authorization may result in you being financially responsible for a denied service. If you need help understanding your individual policy or to inquire if a certain service is covered or requires authorization, call Member Services for assistance.

In this section, the term "continuing care patient" means an individual who, with respect to a provider or facility:

a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

b. is undergoing a course of institutional or inpatient care from the provider or facility.

c. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative

care from such provider or facility with respect to such a surgery;

d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. is or was determined to be terminally ill (as determined under section 1395x(dd)(3)(A) of this title) and is receiving treatment for such illness from such provider or facility.

If Community First terminates a contractual relationship with a provider or facility while an enrollee is a continuing care patient (except for terminations due to failure to meet applicable quality standards or for fraud), the organization shall (i) notify the enrollee of such termination and the enrollee's right to elect continued transitional care from such provider or facility; (ii) permit the enrollee to continue the course of treatment furnished by such provider or facility relating to such continuing transitional care under the same terms and conditions as would have applied if the contract had not been terminated, until the earlier of 90-days or the date on which enrollee is no longer a continuing care patient with respect to such provider or facility.

If you have concerns about the services you have received from Community First, a Community First Preferred Provider, or any aspect of your health plan benefits, please call Member Services. You may also submit a complaint through our online secure Member Portal at UniversityCommunityCarePlan.com.

A full investigation of your complaint will be completed, and our decisions will be forwarded to you in writing within 30 calendar days from receipt of your written complaint or complaint form. Community First will not discriminate or take punitive action against a Member or a Member's representative for making a complaint, an appeal, or an expedited appeal. Community First will not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group or enrollee or person acting on behalf of the group or enrollee has filed a complaint against Community First or appealed a decision of Community First. Community First will not engage in retaliatory action, including refusal to renew or termination of a contract, against a physician or Provider because the physician or Provider has, on behalf of an enrollee, reasonably filed a complaint against Community First or appealed a decision of Community First.

At any time, you may file a complaint with the Texas Department of Insurance (TDI) by writing or calling:

Texas Department of Insurance (TDI)
P.O. Box 149104
Austin, Texas 78714-9104
1-800-252-3439

G. List of Preferred Providers

Community First maintains a thorough Provider Network. Please visit UniversityCommunityCarePlan.com to view our Provider network and a list of Providers that can meet your needs.

H. Service Area Map

The University Community Care Plan service area is Bexar County.

I. Bexar County Demographics

a. Bexar county has just over 2 million residents, of which approximately 1.6 million are insured.

b. Community First Provider Access by Group

   i. Internal Medicine – 19 Providers
   ii. Family/General Practice – 169 Providers
   iii. Pediatric Providers – 5 Providers
   iv. Obstetrics and Gynecology – 72 Providers
   v. Anesthesiology – 60 Providers
   vi. Psychiatry – 55 Providers
   vii. General Surgery – 63 Providers

c. Facilities. An Access Plan is available by contacting Community First Network Management at (210) 358-6400 or toll-free at 1-888-512-2347.

   i. University Hospital
   ii. Robert B. Green Campus
   iii. Texas Diabetes Institute
   iv. MGA Homecare
   v. The Enclave
   vi. The Heights on Huebner
   vii. Stone Oak Care Center
   viii. Heritage Nursing & Rehabilitation
   ix. University Family Health Center - Southeast
   x. University Health Huebner Commons
   xi. University Health Inwood
   xii. University Family Health Center - Southwest
   xiii. University Health Babcock
   xiv. University Family Health Center - North
   xv. Medical Center Pavilion
   xvi. University Health Westgate
   xvii. Access Quality Therapy Services, LLC
   xviii. Laurel Ridge Treatment Center

Community First Insurance Plans does not have any waivers or local market access plans approved relating to Waiver Due to Failure to Contract in Local Markets. The organization is only operating in the Bexar County Market, which entirely comprises its Network of Providers and Facilities.