

COMMUNITY FIRST INSURANCE PLANS

SCHEDULE OF BENEFITS AND COST SHARING

University Community Care Plan by Community First – Silver 87 Standard Plan

The following chart summarizes the coverage available under Your Exclusive Provider Organization (EPO) Policy. For details, refer to COVERED SERVICES AND BENEFITS. All Covered Services (except in emergencies) must be provided by or through a Participating Primary Care Physician/Practitioner, who may authorize You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals, or by a Participating Specialist. Some services may require Preauthorization by Community First.

IMPORTANT NOTE: Copayments/Coinsurance shown below indicates the amount You are required to pay, are expressed as either a fixed dollar amount or a percentage of the Allowable Amount and will be applied for each occurrence, unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law.

In Network Maximum Out of Pocket:

Individual: \$3,000

Family: \$6,000

In Network Medical Deductible:

Individual: \$800

Family: \$1,600

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 Insured	\$3,000
Per Family	\$6,000

Deductibles Per Calendar Year Including Pharmacy Benefits	
Per Individual Insured	\$800
Per Family	\$1,600
Professional Services	
Primary Care Physician/Practitioner (“PCP”) Office or Home Visit	\$20 copay
Participating Specialist Physician (“Specialist”) Office or Home Visit	\$40 copay
Inpatient Hospital Services	
Inpatient Hospital Services, physician/surgeon fee, per visit	\$20 copay
*Inpatient Hospital Services, facility fee, for each admission	30% coinsurance after deductible
Outpatient Surgery Physician and Facility Services	
Outpatient Surgery – Physician Services, per visit	30% coinsurance after deductible
Outpatient Surgery - Hospital Setting	30% coinsurance after deductible
Outpatient Surgery - Other Facility Setting	30% coinsurance after deductible
Radiation Therapy	30% coinsurance after deductible
Dialysis, per visit	\$40 copay
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug - Hospital Setting, per visit	\$40 copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit	\$40 copay
+Non-Maintenance Drug, per visit	\$40 copay
+Chemotherapy	30% coinsurance after deductible
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	30% coinsurance after deductible
Other X-Ray Services	30% coinsurance after deductible
+Outpatient Lab (*Genetic Testing Requires Authorization)	30% coinsurance after deductible

Rehabilitation and Habilitation Services	
<p>*Rehabilitation Services, Habilitation Services and Therapies, per visit:</p> <p>Limited to 35 visits per Calendar Year for Rehabilitation Services</p> <p>Limited to 35 visits per Calendar Year for Habilitation Services</p> <p>Visit limitations do not apply to Behavioral Health Services or the treatment of an acquired brain injury.</p> <p>Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation and habilitation services visit maximums.</p>	<p>\$20 copay unless otherwise covered under Inpatient Hospital Services</p>
Chiropractic Care	
<p>Chiropractic Care (35 visits per year) (+Authorization for Chiropractic not required)</p>	<p>\$40 copay per visit</p>
Maternity Care and Family Planning Services	
<p>Maternity Care</p> <p>Prenatal and Postnatal Visit – After the initial office visit, Subsequent office visits are covered in full</p> <p>Childbirth/Delivery professional services, per visit</p> <p>Inpatient Hospital Services, for each admission</p>	<p>\$20 copay</p> <p>\$40 copay</p> <p>30% coinsurance after deductible</p>
<p>Family Planning Services</p> <p>Diagnostic counseling, consultations and planning services, per visit</p> <p>Insertion or removal of intrauterine device (IUD), including cost of device</p> <p>Diaphragm or cervical cap fitting, including cost of device</p> <p>Insertion or removal of birth control device implanted under the skin, including cost of device</p>	<p>\$20 copay for PCP</p> <p>\$40 copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services</p>

Injectable contraceptive drugs, including cost of drug	
Vasectomy	30% coinsurance after deductible for Inpatient Hospital Services; 30% coinsurance after deductible 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, per visit	\$20 copay for PCP \$40 copay for Specialist
Behavioral Health Services	
+Outpatient Mental Health Care, per visit	\$20 copay
*Inpatient Mental Health Care, per stay	Any charges described in Inpatient Hospital Services will apply.
+Serious Mental Illness, per visit	\$20 copay
+Chemical Dependency Services, per visit	\$20 copay
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit	30% coinsurance after deductible; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.)
Urgent Care	
Urgent Care Services, per visit	\$30 copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Ambulance Services	
+Ambulance Services, emergency medical transportation, per transport	\$40 copay
Extended Care Services	
* Skilled Nursing Facility Services , for each day, up to 25 days per calendar year	30% coinsurance after deductible
Hospice Care , for each day	\$40 copay
* Home Health Care , per visit, up to 60 visits per Calendar Year	\$40 copay
Health Maintenance and Preventive Services	
Well-child care through age 17	No copay
Periodic health assessments for Insured age 18 and older	No copay

<p>Immunizations</p> <ul style="list-style-type: none"> -Childhood immunizations required by law for Insured through age 6 -Immunizations for Insured 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
<p>Screening mammogram for female Insured age 35 and over, and for female Insured with other risk factors, once every twelve months</p> <ul style="list-style-type: none"> -Outpatient facility or imaging centers 	No copay
<p>Contraceptive Services and Supplies</p> <ul style="list-style-type: none"> -Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices. <p>Breastfeeding Support, Counseling and Supplies</p> <ul style="list-style-type: none"> -Electric breast pumps are limited to one per Calendar Year. 	No copay
<p>Hearing Loss</p> <ul style="list-style-type: none"> -Screening test from birth through 30 days -Follow-up care from birth through 24 months 	No copay
<p>Rectal screening for the detection of colorectal cancer for Insured age 50 and older:</p> <ul style="list-style-type: none"> -Annual fecal occult blood test, once every twelve months -Flexible sigmoidoscopy with hemocult of the stool, limited to 1 every 5 years -Colonoscopy, limited to 1 every 10 years 	No copay
<p>Eye and ear screenings for Insured through age 17, once every twelve months</p> <p>Eye and ear screening for Insured age 18 and older, once every two years</p> <p>Note: Covered children to age 19 do have additional benefits as described in PEDIATRIC VISION CARE BENEFITS</p>	<p>\$20 copay for PCP</p> <p>\$20 copay for PCP</p> <p>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.</p>

Early detection test for cardiovascular disease, limited to 1 every 5 years - Computer tomography (CT) scanning - Ultrasonography	30% coinsurance after deductible
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	30% coinsurance after deductible
Exam for prostate cancer, once every twelve months	\$20 copay for PCP \$40 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), per visit	30% coinsurance after deductible for outpatient surgery physician; and Outpatient Surgery charges as described in Outpatient Facility Services; or 30% coinsurance after deductible for Inpatient Hospital Services.
Pediatric Dental Services	
*Pediatric Dental Services (for Insured up to 19 years of age)	Routine dental checkups are not covered. Limited dental services as detailed in Pediatric Dental Services .
Cosmetic, Reconstructive or Plastic Surgery	
*Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	30% coinsurance after deductible for outpatient surgery physician; and Outpatient Surgery charges as described in Outpatient Facility Services;, or 30% coinsurance after deductible for Inpatient Hospital Services
Allergy Care	
Testing and Evaluation Injections Serum	\$40 copay
Diabetes Care	
Diabetes Self-Management Training , for each visit	No copay
Diabetes Equipment	\$40 copay

<p>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.</p>	<p>\$40 copay</p>
<p>Prosthetic Appliances and Orthotic Devices</p>	
<p>*Prosthetic Appliances and Orthotic Devices *Hearing Aids Per hearing aid, Limited to one (1) hearing aid per ear every 36 months. *Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiological necessary.</p>	<p>\$40 copay \$40 copay \$40 copay Any Outpatient Surgery charges described in Outpatient Facility Services may also apply</p>
<p>Durable Medical Equipment</p>	
<p>*Durable Medical Equipment</p>	<p>\$40 copay</p>
<p>Speech and Hearing Services</p>	
<p>+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.</p>	<p>Copay same as any other physical illness.</p>
<p>Telehealth and Telemedicine Medical Services</p>	
<p>Telehealth and Telemedicine</p>	<p>Copay same as any other physical illness or behavioral health visit.</p>
<p>Prescription Drugs</p>	
<p>Generic Preferred Brand Drugs Non-preferred brand drugs +Specialty Drugs</p>	<p>\$10 copay \$20 copay \$60 copay after deductible \$250 copay after deductible</p>