COMMUNITY FIRST INSURANCE PLANS

SCHEDULE OF BENEFITS AND COST SHARING

University Community Care Plan by Community First - Gold Plan
Zero Cost Share 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: $0
Family: $0

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 Insured	$0
Per Family	$0
Deductibles Per Calendar Year Including Pharmacy Benefits	

Per Individual Insured	$0
Per Family	$0
Professional Services	
Primary Care Physician/Practitioner (“PCP”) Office or Home Visit	No copay
Participating Specialist Physician (“Specialist”) Office or Home Visit	No copay
Inpatient Hospital Services	
Inpatient Hospital Services, physician/ surgeon fee, per visit	No copay
*Inpatient Hospital Services, facility fee, for each admission	No copay
Outpatient Surgery Physician and Facility Services	
Outpatient Surgery – Physician Services, per visit	No copay
Outpatient Surgery- Hospital Setting	No copay
Outpatient Surgery- Other Facility Setting	No copay
Radiation Therapy	No copay
Dialysis, per visit	No copay
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug - Hospital Setting, per visit	No copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit	No copay
+Non-Maintenance Drug, per visit	No copay
+Chemotherapy	No 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	No copay
Other X-Ray Services	No copay
+Outpatient Lab (*Genetic Testing Requires Authorization)	No copay

Rehabilitation and Habilitation Services	
***Rehabilitation Services, Habilitation Services and Therapies**, per visit: Limited to 35 visits per Calendar Year for Rehabilitation Services Limited to 35 visits per Calendar Year 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.	No copay
Chiropractic Care	
Chiropractic Care (35 visits per year) (+Authorization for Chiropractic not required)	No copay
Maternity Care and Family Planning Services	
Maternity Care Prenatal and Postnatal Visit – After the initial office visit, subsequent office visits are covered in full Childbirth/Delivery professional services, per visit Inpatient Hospital Services, for each admission	No copay No copay No copay
Family Planning Services Diagnostic counseling, consultations and family planning services, per visit 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	No copay

Injectable contraceptive drugs, including cost of drug	
Vasectomy	No copay
Infertility Services Diagnostic counseling, consultations, familyplanning services and treatment services, per visit	No copay
Behavioral Health Services	
+Outpatient Mental Health Care, per visit	No copay
*Inpatient Mental Health Care, per stay	No copay
+Serious Mental Illness, per visit	No copay
+Chemical Dependency Services, per visit	No copay
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit	No copay
Urgent Care	
Urgent Care Services, per visit	No copay
Ambulance Services	
*Ambulance Services, emergency medical services, per transport	No copay
Extended Care Services	
***Skilled Nursing Facility Services**, for each day, up to 25 days per calendar year	No copay
Hospice Care, for each day	No copay
***Home Health Care**, per visit, up to 60 visits per Calendar Year	No 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
Immunizations *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
Screening mammogram for female Insured age 35 and over, and for female Insured 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 Insured 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 Insured through age 17, once every twelve months Eye and ear screening for Insured age 18 and older, once every two years Note: Covered children to age 19 have additional benefits as described inPEDIATRIC VISION CARE BENEFITS. Routine eye exams and refractions are not a covered benefit for age 20 and above.	No copay No copay
Early detection test for cardiovascular disease, limited to 1 every 5 years * Computer tomography (CT) scanning * Ultrasonography	No copay
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	No copay
Exam for prostate cancer, once every twelve months	No copay
Dental Surgical Procedures	
*Dental Surgical Procedures (limited Covered Services) General and routine dental checkups and services are Not Covered for adults or children.	No copay
Cosmetic, Reconstructive or Plastic Surgery	
*Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	No copay
Allergy Care	

Testing and Evaluation Injections Serum	No copay
Diabetes Care	
Diabetes Self-Management Training, for each visit	No copay
Diabetes Equipment	No 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.	No copay
Prosthetic Appliances and Orthotic Devices	
***Prosthetic Appliances and Orthotic Devices**	No copay
***Hearing Aids** Per hearing aid, Limited to one (1) hearing aid per ear every 36 months.	No copay
***Cochlear Implants** Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	No copay
Durable Medical Equipment	
***Durable Medical Equipment**	No 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.	Copay same as any other physical illness.
Telehealth and Telemedicine Medical Services	
Telehealth and Telemedicine Medical Services	Copay same as any other physical illness or behavioral health visit.
Prescription Drugs	
Generic	No copay
Preferred Brand Drugs	No copay
Non-preferred brand drugs	No copay
+**Specialty Drugs**	No copay, No coinsurance