# COMMUNITY FIRST INSURANCE PLANS

## SCHEDULE OF BENEFITS AND COST SHARING

***University Community Care Plan by Community First - Gold Standard Plan***
(On-Exchange, Off-Exchange)

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: $7,800
Family: $15,600

**In Network Medical Deductible:**
Individual: $1,500
Family: $3,000

**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 | $7,800 |
| Per Family | $15,600 |
| **Deductibles Per Calendar Year Including Pharmacy Benefits** | |
| Per Individual Insured | $1,500 |
| Per Family | $3,000 |
| **Professional Services** | |
| Primary Care Physician/Practitioner ("PCP") Office or Home Visit | $30 copay |
| Participating Specialist Physician ("Specialist") Office or Home Visit | $60 copay |
| **Inpatient Hospital Services** | |
| Inpatient Hospital Services, physician/ surgeon fee, per visit | 25% coinsurance after deductible |
| *Inpatient Hospital Services, facility fee, for each admission | 25% coinsurance after deductible |
| **Outpatient Surgery Physician and Facility Services** | |
| Outpatient Surgery – Physician Services, per visit | 25% coinsurance after deductible |
| Outpatient Surgery - Hospital Setting | 25% coinsurance after deductible |
| Outpatient Surgery - Other Facility Setting | 25% coinsurance after deductible |
| Radiation Therapy | 25% coinsurance after deductible |
| Dialysis, per visit | $60 copay |
| **Outpatient Infusion Therapy Services** | |
| +Routine Maintenance Drug - Hospital Setting, per visit | $60 copay |
| +Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit | $60 copay |
| +Non-Maintenance Drug, per visit | $60 copay |
| +Chemotherapy | 25% 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 | 25% coinsurance after deductible |
| Other X-Ray Services | 25% coinsurance after deductible |
| +Outpatient Lab (*Genetic Testing Requires Authorization) | 25% coinsurance after deductible |

| | |
|---|---|
| **Rehabilitation and Habilitation Services** | |
| ***Rehabilitation Services, Habilitation Services and Therapies**, per visit:<br><br>Limited to 35 visits per Calendar Year for Rehabilitation Services (+Authorization for Chiropractic not required)<br><br>Limited to 35 visits per Calendar Year for Habilitation Services<br>Visit limitations do not apply to Behavioral Health Services or the treatment of an acquired brain injury.<br><br>Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation and habilitation services visit maximums. | $30 copay unless otherwise covered under Inpatient Hospital Services |
| **Chiropractic Care** | |
| **Chiropractic Care (35 visits per year)** (+Authorization for Chiropractic not required) | $60 copay per visit |
| **Maternity Care and Family Planning Services** | |
| **Maternity Care**<br><br>Prenatal and Postnatal Visit – After the initial office visit, subsequent office visits are covered in full<br>Childbirth/Delivery professional services, per visit<br>Inpatient Hospital Services, for each admission | $30 copay<br><br>No copay<br><br>25% coinsurance after deductible |
| **Family Planning Services**<br>Diagnostic counseling, consultations and planning services, per visit<br>Insertion or removal of intrauterine device (IUD), including cost of device<br>Diaphragm or cervical cap fitting, including cost of device<br>Insertion or removal of birth control device implanted under the skin, including cost of device<br>Injectable contraceptive drugs, including cost of drug | $30 copay for PCP<br>$60 copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services |

| | |
|---|---|
| Vasectomy | 25% coinsurance per stay, after deductible, for Inpatient Hospital Services;<br>25% coinsurance per visit, after deductible, for Outpatient Facility Services |
| **Infertility Services**<br>Diagnostic counseling, consultations, family planning services and treatment services, per visit | <br>$30 copay for PCP<br>$60 copay for Specialist |
| Behavioral Health Services | |
| +Outpatient Mental Health Care, per visit | $30 copay |
| *Inpatient Mental Health Care, per stay | 25% coinsurance after deductible |
| +Serious Mental Illness, per visit | $30 copay |
| +Chemical Dependency Services, per visit | $30 copay |
| Emergency Services | |
| Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit | 25% coinsurance after deductible; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.) |
| Urgent Care | |
| Urgent Care Services, per visit | $45 copay<br>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply. |
| Ambulance Services | |
| *Ambulance Services, emergency medical transportation, per transport | 25% coinsurance after deductible |
| Extended Care Services | |
| ***Skilled Nursing Facility Services**, for each day, up to 25 days per calendar year | 25% coinsurance after deductible |
| **Hospice Care**, for each day | $60 copay |
| ***Home Health Care**, per visit, up to 60 visits per Calendar Year | $60 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<br>-Childhood immunizations required by law for Insured through age 6<br>-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<br>-Outpatient facility or imaging centers | No copay |
| Contraceptive Services and Supplies<br>-Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices.<br><br>Breastfeeding Support, Counseling and Supplies<br>-Electric breast pumps are limited to one per Calendar Year. | No copay |
| Hearing Loss<br>-Screening test from birth through 30 days<br>-Follow-up care from birth through 24 months | No copay |
| Screening for the detection of colorectal cancer for Insured age 45 and older:<br><br>-All colorectal cancer examinations, preventative services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventative Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and<br>- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal. | No copay |
| Eye and ear screenings for Insured through age 17, once every twelve months<br><br>Eye and ear screening for Insured age 18 and older, once every two years<br><br>Note: Covered children to age 19 have additional benefits as described in PEDIATRIC VISION CARE BENEFITS. | $30 copay for PCP<br><br>$30 copay for PCP<br><br>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply. |

| | |
|---|---|
| Routine eye exams and refractions are not a covered benefit for age 20 and above. | |
| Early detection test for cardiovascular disease, limited to 1 every 5 years<br><br>- Computer tomography (CT) scanning<br>- Ultrasonography | 25% coinsurance after deductible |
| Early detection test for ovarian cancer (CA125 blood test), once every twelve months | 25% coinsurance after deductible |
| Exam for prostate cancer, once every twelve months | $30 copay for PCP<br>$60 copay for Specialist<br><br>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply. |
| Dental Surgical Procedures | |
| *Dental Surgical Procedures (limited Covered Services)<br><br>**General and routine dental checkups and services are Not Covered for adults or children.** | 25% coinsurance after deductible for Outpatient Surgery charges as described in Outpatient Facility Services, per visit, or<br><br>25% coinsurance after deductible for Inpatient Hospital Services, per visit, or<br><br>For services provided in a Participating Provider's office, see "Professional Services". |
| Cosmetic, Reconstructive or Plastic Surgery | |
| *Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services) | 25% coinsurance after deductible for Outpatient Surgery charges as described in Outpatient Facility Services, or<br><br>25% coinsurance after deductible for Inpatient Hospital Services |
| Allergy Care | |

| | |
|---|---|
| Testing and Evaluation<br>Injections<br>Serum | $60 copay |
| **Diabetes Care** | |
| **Diabetes Self-Management Training**, for each visit | No copay |
| **Diabetes Equipment** | $60 copay |
| **Diabetes Supplies**<br>Diabetes Supplies are 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** | $60 copay |
| ***Hearing Aids**<br>Per hearing aid, Limited to one (1) hearing aid per ear every 36 months. | $60 copay |
| ***Cochlear Implants**<br>Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary. | $60 copay<br>Any Outpatient Surgery charges described in Outpatient Facility Services may also apply |
| **Durable Medical Equipment** | |
| ***Durable Medical Equipment** | $60 copay |
| **Speech and Hearing Services** | |
| +**Speech and Hearing Services**<br>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** | Copay same as any other physical illness or behavioral health visit. |
| **Prescription Drugs** | |
| **Generic** | $15 copay |
| **Preferred Brand Drugs** | $30 copay |
| **Non-preferred brand drugs** | $60 copay |
| +**Specialty Drugs** | $250 copay |