

COMMUNITY FIRST
MARKETPLACE
UNIVERSITY COMMUNITY
CARE PLAN



UNIVERSITY COMMUNITY CARE PLAN
2026 SCHEDULE OF BENEFITS
SILVER STANDARD PLAN LIMITED COST SHARE

**COMMUNITY FIRST INSURANCE PLANS
SCHEDULE OF BENEFITS AND COST SHARING**

*University Community Care Plan by Community First – Silver Standard Plan
Limited Cost Share*

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: \$8,900

Family: \$17,800

In-Network Medical Deductible:

Individual: \$6,000

Family: \$12,000

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 preauthorization requirements are listed in the Health Insurance Exchange Preauthorization List.

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 Insured	\$8,900
Per Family	\$17,800
Deductibles Per Calendar Year, Including Pharmacy Benefits	
Per Individual Insured	\$6,000
Per Family	\$12,000
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	\$40 copay
Participating Specialist Physician ("Specialist") Office or Home Visit	\$80 copay

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Inpatient Hospital Services	
Inpatient Hospital Services , physician/surgeon fee, per visit	No copay
*Inpatient Hospital Services , facility fee, for each admission	40% coinsurance, after deductible
Outpatient Surgery Physician and Facility Services	
Outpatient Surgery – Physician Services, per visit	40% coinsurance, after deductible
Outpatient Surgery – Hospital Setting	40% coinsurance, after deductible
Outpatient Surgery – Other Facility Setting	40% coinsurance, after deductible
Radiation Therapy	40% coinsurance, after deductible
Dialysis , per visit	\$80 copay
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug – Hospital Setting, per visit	\$80 copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit	\$80 copay
+Non-Maintenance Drug , per visit	\$80 copay
+Chemotherapy	40% 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	40% coinsurance, after deductible
Other X-Ray Services	40% coinsurance, after deductible
+Outpatient Lab (*Genetic Testing requires authorization)	40% coinsurance, after deductible
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.	\$40 copay unless otherwise covered under Inpatient Hospital Services

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Chiropractic Care	
Chiropractic Care (35 visits per year) (+Authorization for Chiropractic not required)	\$80 copay per visit
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	\$40 copay No copay 40% coinsurance, after deductible
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 Injectable contraceptive drugs, including cost of drug	\$40 copay for PCP \$80 copay for Specialist, unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services
Vasectomy	40% coinsurance, after deductible, for Inpatient Hospital Services 40% coinsurance, after deductible, for Outpatient Facility Services 40% coinsurance, after deductible, for Outpatient Physician Services
Infertility Services Diagnostic counseling, consultations, family planning services, and treatment services, per visit	\$40 copay for PCP \$80 copay for Specialist
Behavioral Health Services	
+Outpatient Mental Health Care , per visit	\$40 copay
*Inpatient Mental Health Care , per stay	Any charges described in Inpatient Hospital Services will apply
+Serious Mental Illness , per visit	\$40 copay
+Chemical Dependency Services , per visit	\$40 copay
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit	40% coinsurance, after deductible; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply)
Urgent Care	
Urgent Care Services , per visit	\$60 copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply

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Ambulance Services	
*Ambulance Services , emergency medical services, per transport	40% coinsurance, after deductible
Extended Care Services	
*Skilled Nursing Facility Services , for each day, up to 25 days per calendar year	40% coinsurance, after deductible
Hospice Care , for each day	\$80 copay
*Home Health Care , per visit, up to 60 visits per calendar year	\$80 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, two allowed per year	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 insured age 35 and over, and for female insured with other risk factors, once every 12 months Ages 35-39 one baseline allowed Ages 40 and older; one per year *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

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<p>Screening for the Detection of Colorectal Cancer for insured age 45 and older:</p> <p>*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</p> <p>*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.</p> <p>-Annual fecal occult blood test, once every 12 months</p> <p>-Flexible sigmoidoscopy with hemoccult of the stool, limited to one every five years</p> <p>-Colonoscopy, limited to one every 10 years</p> <p>Colonoscopies are considered diagnostic and would follow the Outpatient Surgery Schedule</p>	<p>No copay</p>
<p>Eye and Ear Screenings for insured through age 17, once every 12 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 have additional benefits as described in Pediatric Vision Care. Routine eye exams and refractions are not a covered benefit for age 20 and above.</p>	<p>\$40 copay for PCP</p> <p>\$40 copay for PCP</p> <p>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply</p>
<p>Early Detection Test for Cardiovascular Disease, limited to one every five years</p> <p>*Computer tomography (CT) scanning</p> <p>*Ultrasonography</p>	<p>40% coinsurance, after deductible</p>
<p>Early Detection Test for Ovarian Cancer (CA125 blood test), once every 12 months</p>	<p>40% coinsurance, after deductible</p>
<p>Exam for Prostate Cancer, once every 12 months</p>	<p>\$40 copay for PCP</p> <p>\$80 copay for Specialist</p> <p>Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply</p>
Dental Surgical Procedures	
<p>*Dental Surgical Procedures (limited covered services)</p> <p>General and routine dental checkups and services are not covered for adults or children.</p>	<p>40% coinsurance, after deductible, for Outpatient Facility Services, per visit</p> <p>40% coinsurance, after deductible, for Outpatient Physician Services, per visit</p> <p>40% coinsurance, after deductible, for Inpatient Hospital Services, per visit</p> <p>For services provided in a participating provider’s office, see Professional Services</p>

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Cosmetic, Reconstructive or Plastic Surgery	
*Cosmetic, Reconstructive, or Plastic Surgery (limited covered services)	40% coinsurance, after deductible, for Outpatient Facility Services, per visit 40% coinsurance, after deductible, for Outpatient Physician Services, per visit 40% coinsurance, after deductible, for Inpatient Hospital Services
Allergy Care	
Testing and Evaluation Injections Serum	\$80 copay
Diabetes Care	
Diabetes Self-Management Training , for each visit Diabetes Equipment 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 \$80 copay No copay
Prosthetic Appliances and Orthotic Devices	
*Prosthetic Appliances and Orthotic Devices *Hearing Aids , per hearing aid, limited to one hearing aid per ear every 36 months *Cochlear Implants , limit one per impaired ear with replacements as medically necessary or audiological necessary	\$80 copay \$80 copay \$80 copay Any Outpatient Surgery charges described in Outpatient Facility Services may also apply
Durable Medical Equipment	
*Durable Medical Equipment	\$80 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	
Zero Cost Share Generic Preferred Brand Drugs Non-Preferred Brand Drugs +Specialty Drugs	\$0 copay \$20 copay \$40 copay \$80 copay, after deductible \$350 copay, after deductible



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