COMMUNITY FIRST CARE PLAN

2027 SCHEDULE OF BENEFITS

GOLD PLAN (LIMITED COST SHARING)

COMMUNITY FIRST INSURANCE PLANS

SCHEDULE OF BENEFITS AND COST SHARING

Community First Care Plan – Gold Plan
(Limited Cost Sharing)

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: $8,500
Family: $17,000

In-Network Medical Deductible:
Individual: $750
Family: $1,500

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	$8,500
Per Family	$17,000
Deductibles Per Calendar Year, Including Pharmacy Benefits	
Per Individual Insured	$750
Per Family	$1,500
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$35 copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$70 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	30% coinsurance after deductible per stay
Outpatient Surgery Physician and Facility Services	
Outpatient Surgery – Physician Services, per visit	$600 copay
Outpatient Surgery – Hospital Setting	$105 copay
Outpatient Surgery – Other Facility Setting	$105 copay
Radiation Therapy	$105 copay
Dialysis, per visit	$105 copay
Outpatient Infusion Therapy Services	
+Routine Maintenance Drug – Hospital Setting, per visit	$105 copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit	$105 copay
+Non-Maintenance Drug, per visit	$105 copay
+Chemotherapy	$105 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	$125 copay
Other X-Ray Services	$125 copay
+Outpatient Lab (*Genetic Testing requires authorization)	$125 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.	$105 copay per modality unless otherwise covered under Inpatient Hospital Services

Chiropractic Care	
Chiropractic Care (35 visits per year) (+Authorization for Chiropractic not required)	$70 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	$35 copay
Childbirth/Delivery professional services, per visit	No copay
Inpatient Hospital Services, for each admission	30% coinsurance after deductible
Family Planning Services	
Diagnostic counseling, consultations, and family planning services, per visit	$35 copay for PCP $70 copay for Specialist, unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive 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	
Vasectomy	30% coinsurance after deductible for Inpatient Hospital Services $105 copay for Outpatient Facility Services $600 copay for Outpatient Physician Services
Infertility Services	
Diagnostic counseling, consultations, family planning services, and treatment services, per visit	$35 copay for PCP $70 copay for Specialist
Behavioral Health Services	
+Outpatient Mental Health Care, per visit	$35 copay
***Inpatient Mental Health Care,** per stay	Any charges described in Inpatient Hospital Services will apply
+Serious Mental Illness, per visit	$35 copay
+Chemical Dependency Services, per visit	$35 copay
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit	$250 copay; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply)
Urgent Care	
Urgent Care Services, per visit	$35 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	$250 copay
Extended Care Services	
***Skilled Nursing Facility Services**, for each day, up to 25 days per calendar year	30% coinsurance after deductible per day
Hospice Care, for each day	$70 copay
***Home Health Care**, per visit, up to 60 visits per calendar year	$35 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

Note: Preauthorization and other utilization management requirements are applied in compliance with applicable mental health parity laws and will not be applied more stringently to mental health or substance use disorder benefits than to medical/surgical benefits.

Screening for the Detection of Colorectal Cancer for insured age 45 and older: *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 *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. -Annual fecal occult blood test, once every 12 months -Flexible sigmoidoscopy with hemoccult of the stool, limited to one every five years -Colonoscopy, limited to one every 10 years Colonoscopies are considered diagnostic and would follow the Outpatient Surgery Schedule	No copay
Eye and Ear Screenings for insured through age 17, once every 12 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 in Pediatric Vision Care. Routine eye exams and refractions are not a covered benefit for age 20 and above.	$35 copay for PCP $35 copay for PCP 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 five years *Computer tomography (CT) scanning *Ultrasonography	$125 copay
Early Detection Test for Ovarian Cancer (CA125 blood test), once every 12 months	$125 copay
Exam for Prostate Cancer, once every 12 months	$35 copay for PCP $70 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) General and routine dental checkups and services are not covered for adults or children.	$105 copay for Outpatient Facility Services, per visit $600 copay for Outpatient Physician Services, per visit or: 30% coinsurance for Inpatient Hospital Services, per visit 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)	$105 copay for Outpatient Facility Services, per visit $600 copay for Outpatient Physician Services, per visit or: 30% coinsurance for Inpatient Hospital Services
Allergy Care	
Testing and Evaluation **Injections** **Serum**	$70 copay
Diabetes Care	
Diabetes Self-Management Training, for each visit	No copay
Diabetes Equipment	$35 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**	$35 copay
***Hearing Aids,** per hearing aid, limited to one hearing aid per ear every 36 months	$70 copay
***Cochlear Implants,** limit one per impaired ear with replacements as medically necessary or audiologically necessary	$35 copay Any Outpatient Surgery charges described in Outpatient Facility Services may also apply
Durable Medical Equipment	
***Durable Medical Equipment**	$35 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	No copay
Generic	$10 copay
Preferred Brand Drugs	$25 copay
Non-Preferred Brand Drugs	$50 copay
+Specialty Drugs	30% coinsurance after deductible

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