

**UNIVERSITY FAMILY CARE PLAN**  
**SCHEDULE OF BENEFITS, CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES**

The following chart shows eligible services and supplies for your coverage. This schedule is intended to be a summary. Some of these benefits are subject to limitations and exclusions described in the Summary of Benefits. Please review the University Family Care Plan Summary of Benefits regarding balance billing for Non-Participating Providers. The Co-payment and Out-of-Pocket amounts are shown at the right. If there is no Co-payment, the service or supply shown will be covered at 100 percent (UHS Network). Members are responsible for the payment of Co-payments upon receipt of some of the Covered Services described below. The maximum Out-of-Pocket payable in each Contract Year is listed below. When a Member or a Family Unit has paid the applicable maximum Out-of-Pocket, all Covered Services will be provided with no further Co-payments for the balance of the Contract Year (Expanded Network). **Co-payments for prescription drugs and infertility testing and treatment are not applicable to any annual Out-Of-Pocket maximums. No lifetime maximum.**

<b>Annual Deductible</b>		
	UHS Network	Expanded (First Health) Network
Individual/Family Annual Out-of-Pocket	None	\$600/\$1,200
Maximum (after deductible) Individual/Family	None	\$4,800/\$9,600

**Basic Coverage:**

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Physician Services</b>	Office Visits	\$15 co-payment per visit	30% co-insurance after deductible
	Telephone Visits	\$5 co-payment per visit, UMA PCP Only	Not a covered benefit
	Inpatient Hospital Visits	No co-payment	30% co-insurance after deductible
	Allergy Testing and Treatment	\$15 co-payment per visit	30% co-insurance after deductible
	Prenatal Visits	\$15 co-payment, first visit only	30% co-insurance after deductible
	Specialty Medical Injectable Office Visit and Medications	\$15 co-payment per visit	30% co-insurance after deductible
	Smoking Cessation ( <b>Annual benefit limit of \$300 for Rx only.</b> )	\$15 co-payment per visit	30% co-insurance after deductible

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Preventive Care Services</b>  <i>(Furnished, authorized or arranged by a Provider during an office visit.)</i>	Pediatric and Adult Immunizations	No co-payment	30% co-insurance after deductible
	*Well woman exam - one per plan year.	No co-payment	30% co-insurance after deductible
	<b>Cancer Screenings, including:</b>		
	* <sup>1</sup> Colorectal Cancer Screening	No co-payment	30% co-insurance after deductible
	* <sup>3</sup> Cervical Cancer Screening	No co-payment	30% co-insurance after deductible
	* <sup>1</sup> Exam for Detection and Prevention of Osteoporosis	No co-payment	30% co-insurance after deductible
	Well Baby Care /Well Child Care	No co-payment	30% co-insurance after deductible
	Physical Examinations (Covered annually.)*	No co-payment	30% co-insurance after deductible
*Tubal Ligation	No co-payment	30% co-insurance after deductible	
	<b>*When combined with a Physician Office Visit, only one Co-payment will apply.</b>		
	<i>See page 27-29 of UHS Summary of Benefits for details.</i>		
<b>Family Planning</b>  <b>(Pre-Authorization is required for some Family Planning services)</b>	*Office visits	No co-payment	50% co-insurance after deductible
	Infertility Testing/Treatment & Office Visit <i>See page 23 &amp; 37 of UHS Summary of Benefits for details and exclusions.</i>	50% co-payment	50% co-insurance after deductible
	Infertility Medications <i>See page 23 &amp; 37 of UHS Summary of Benefits for details and exclusions.</i>	50% co-payment	50% co-insurance after deductible
	Vasectomy <i>See page 23 of UHS Summary of Benefits for details.</i>	\$100 co-payment	50% co-insurance after deductible

<sup>1</sup> Subject to language in 13.4.13.3 of the Description of Benefits (zero cost sharing for certain preventive services under the Affordable Care Act)

<sup>3</sup> Subject to language in 13.4.13.5 of the Description of Benefits (zero cost sharing for certain preventive services under the Affordable Care Act)

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Prescribed Medical Services, Supplies, Durable Medical Equipment (DME) and Outpatient Facility</b>  <i>(Furnished, authorized or arranged by provider during an office visit)</i>	Chemotherapy, Radiation Therapy, MRI, PET, CT Scan, SPECT Scans, Mammograms, X-Rays and Diagnostic Laboratory Tests. <b>Outpatient only. (Chemotherapy has an annual benefit limit of \$250,000.)</b>	No co-payment	30% co-insurance after deductible
	Durable Medical Equipment (Rental or purchase.)	No co-payment	30% co-insurance after deductible
	Breast Pump	No co-payment	30% co-insurance after deductible
	Hearing Aids, (Includes batteries – annual benefit limit of \$2,000 max.)	All charges over \$2,000	All charges over \$2,000 (after deductible met) <b>Benefit limit still applies</b>
	Disposable and Other Eligible Supplies	15% co-payment	30% co-insurance after deductible
	Hearing Aid Exam	\$15 co-payment	30% co-insurance after deductible
	Diabetes Equipment and Supplies.	15% co-payment	30% co-insurance after deductible
	Prostheses <b>(Limit of \$10,000 per occurrence per plan year.)</b>	15% co-payment	30% co-insurance after deductible
	Orthotics	No co-payment	30% co-insurance after deductible
	Implantable Devices	Inpatient co-pay applies.	30% co-insurance after deductible
Cochlear Implant <b>(Benefit limit of \$2,000 per plan year.)</b>	No co-payment	30% co-insurance after deductible	
<b>Urgent Care</b>  <i>See page 12 of UHS Summary of Benefits for Details</i>	Covered Services Received at an Urgent Care Center	\$20 co-payment per visit (UHS Express Med Only)	30% co-insurance after deductible

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<p><b>Emergency Room or Observation Period</b></p> <p><i>See pg. 13 of UHS Summary of Benefits for details</i></p>	<p>Members may be required to pay bill in full at a non-participating facility and submit the claim to Community First Health Plans (CFHP) for reimbursement. CFHP will pay for true Emergency Care Services performed by non-participating providers at the negotiated, usual, and customary rate. Member may be responsible for balance of billed charges, if any.</p>	<p>\$100 co-payment per visit If hospitalized, ER Co-pay is waived. Hospital inpatient co-pay will apply.</p> <p><b>University Hospital Emergency Center is the ONLY emergency room in the UHS Network.</b></p>	<p>Co-insurance will apply after the deductible is met. If hospitalized, hospital inpatient co-insurance will apply. <i>See pg. 13 of UHS Summary of Benefits for details</i></p>
<p><b>Hospital Inpatient (Authorization required if outside of UHS)</b></p>	<p>All inpatient covered services and supplies, ICU, delivery, oxygen, hospital, ancillary charges and medications.</p> <p>Newborn Care (48/96-hour delivery stay)</p> <p>Newborn stay beyond the 48/96-hour period</p> <p>Physician's charges, including surgery</p>	<p>\$100 co-payment per day (Five-day co-pay max per confinement)</p> <p>No co-payment</p> <p>\$100 co-payment per day (Five-day co-payment max per confinement)</p> <p>No co-payment</p>	<p>30% co-insurance after deductible</p> <p>No deductible 30% co-insurance will apply</p> <p>30% co-insurance after deductible</p> <p>30% co-insurance after deductible</p>
<p><b>Outpatient Surgery (Preauthorization required if outside of UHS)</b></p>	<p>Services and supplies in connection with surgical treatment</p> <p>Outpatient Surgery (<b>Hospital or facility</b>)</p> <p>Physician Charges</p>	<p>No co-payment</p> <p>\$100 co-payment per visit</p> <p>No co-payment</p>	<p>30% co-insurance after deductible</p> <p>30% co-insurance after deductible</p> <p>30% co-insurance after deductible</p>

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Obesity Treatment (Preauthorization Required)</b>	See Coverage Limitations on page 38 from the <i>Summary of Benefits</i> . <b>Authorization Required.</b>	\$30,000 Life Time Maximum  All co-payments still apply  <b>All procedures and services must be performed at University Hospital, no other facilities.</b>	<b>This treatment is NOT covered under the expanded network.</b>
<b>Outpatient Therapy</b> Physical, Occupational, Speech & Hearing 60 visits regardless of diagnosis.	Outpatient Therapy Physical Therapy - 60 visit max per plan year Occupational Therapy – 60 visit max per plan year Speech and Hearing Therapy - 60 visit max per plan year Pulmonary Rehabilitation Therapy – 20 visit max per plan year Cardiac Rehabilitation Therapy – 36 visit max per plan year.  <b>**Outpatient Therapy visits cannot be combined with Home Health Therapy benefits. See Home Health.</b>	\$15 co-payment per visit	30% co-insurance after deductible
<b>Applied Behavioral Analysis Therapy (ABA)</b>	Outpatient Therapy  Home Health Visit <i>*Must meet Home Health Visit criteria. See page 25 of UHS Certificate of Coverage for benefit details.</i>  <b>**Home Health visits cannot be combined with outpatient therapies benefit.</b>	\$15 co-payment per visit (No visit limitation with ABA diagnosis)  \$15 co-payment per visit (No visit limitation with ABA diagnosis)  <i>**See page 25 of UHS Summary of Benefits for details.</i>	30% co-insurance after deductible  30% co-insurance after deductible

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Skilled Nursing Facility</b>	All covered services and supplies up to 60 days per condition/plan year, including semi-private room, ancillary charges and medications.	\$15 co-payment per day	30% co-insurance after deductible
<b>Behavioral Health Services (Inpatient &amp; Outpatient)</b>	Inpatient covered services and supplies. Residential treatment center for children and adolescents, crisis stabilization unit.  Outpatient visits to include day treatment facility for behavioral illness.	\$100 co-payment per day (Five-day co-payment max per related inpatient stay)  \$15 co-payment per visit	30% co-insurance after deductible  30% co-insurance after deductible
<b>Alcoholism/Chemical Dependency</b>	All medically necessary covered services.  Inpatient   Outpatient	\$100 co-payment per day (Five-day co-payment max per related inpatient stay)  \$15 co-payment per visit	30% co-insurance after deductible  30% co-insurance after deductible
<b>Hospice</b>	Services furnished by a hospice or hospice team.	No In-Network Benefit	30% co-insurance after deductible
<b>Home Health Care</b>	Including, but not limited to, skilled nursing (RN/LVN), physical, occupational, speech or respiratory therapy, medical social services and/or services of a home health aide under the supervision of an RN, only for Members who are homebound or confined to an institution that is not a hospital. Homebound Members are those who have a physical condition such that there is a normal inability to leave the home. <b>**Home Health visits cannot be combined with outpatient therapies benefit.</b>	No co-payment (Total annual limit of 60 visits; per service)	30% co-insurance after deductible.

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Medical Transportation</b>	Emergency ground or air ambulance transportation when medically necessary.* <b>CFHP will pay for Emergency Transportation services performed by non-participating Providers at the negotiated or usual and customary rate. Member may be responsible for balance of billed charges, if any.</b>	Plan will pay up to \$500 of the Usual and Customary	Plan will pay up to \$500 of the Usual and Customary
<b>Vision Services</b>	Comprehensive eye exam (one per year) through Envolve	\$10 co-payment per visit	No In-Network Benefit
<b>Other Covered Services</b>	Psychological testing authorized or arranged by a physician.  Health education services when provided or authorized by a physician for a person's health education, including, but not limited to: diabetes education, asthma education, nutritional counseling and education, etc.	\$15 co-payment per visit  No co-payment	30% co-insurance after deductible  30% co-insurance after deductible

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>CO-PAYMENTS UHS NETWORK</b>	<b>CO-INSURANCE EXPANDED NETWORK</b>
<b>Schedule of Co-payments for Prescription Medications and Maintenance Medications</b>	<p>Preferred Generic Medications Tier 1</p> <p>Preferred Brand Name Medications and Select Generics Tier 2</p> <p>Non-Preferred Medications or Specialty drugs Tier 3</p> <p>Download the Refill Pro App from your iOS or Android app store.</p>	<p>Co-payment waived if filled at a University Health System Pharmacy.</p> <p>Co-payment waived if filled at a University Health System Pharmacy.</p> <p>Co-payment waived if filled at a University Health System Pharmacy.</p>	<p>\$20 (30 day) \$40 (90 day)</p> <p>\$40 (30 day) \$60 (90 day)</p> <p>\$60 (30 day) \$100 (90 day)</p>
<b>Mail Order Prescription Benefit</b>	University Health System Pharmacies	<p>No co-payment Prescription must be written by a University Health System, UMA or UT Health San Antonio physician</p> <p><a href="http://www.universityhealthsystem.com/rxandgo">www.universityhealthsystem.com/rxandgo</a></p>	