University Health | COMMUNITY FIRST HEALTH PLANS

THINKING BEYOND TO SERVE OUR COMMUNITY

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 (UH 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.***

Annual Deductible		
	UH Network	Expanded (First Health) Network
Individual/Family Annual Out-of-Pocket	None	$625/$1,250
Maximum (after deductible) Individual/Family	None	$5,000/$10,000

Basic Coverage:

BENEFIT	***DESCRIPTION***	***CO-PAYMENTS UH NETWORK***	***CO-INSURANCE EXPANDED NETWORK***
Physician Services	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 **(Annual benefit limit of $300 for Rx products only.)**	$15 co-payment per visit	30% co-insurance after deductible

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Preventive Care Services *(Furnished, authorized or arranged by a Provider during an office visit.)*	Pediatric and Adult Immunizations COVID-19 PCR testing limited to 2 per year per covered member *Well woman exam - one per plan year. **Cancer Screenings, including:** *[1]Colorectal Cancer Screening (Multi-target Stool DNA Testing such as Cologuard.) *[3]Cervical Cancer Screening *[1]Exam for Detection and Prevention of Osteoporosis Well Baby Care /Well Child Care Physical Examinations (Covered annually.) * *Tubal Ligation ***When combined with a Physician Office Visit, only one Co-payment will apply.** *See page27-29 of UH Summary of Benefits for details.*	No co-payment $15 co-payment No co-payment No co-payment No co-payment No co-payment No co-payment No co-payment No co-payment	30% co-insurance after deductible 30% co-insurance after deductible 30% co-insurance after deductible 30% co-insurance after deductible 30% co-insurance after deductible 30% co-insurance after deductible 30% co-insurance after deductible

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BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Family Planning ***(Pre-Authorization is required for some Family Planning services)***	*Office visits	No co-payment	50% co-insurance after deductible
	Infertility Testing/Treatment & Office Visit *See page 23-24 & 39 of UH Summary of Benefits for details and exclusions.*	50% co-payment	50% co-insurance after deductible
	Infertility Medications *See page 23 & 37 of UH Summary of Benefits for details and exclusions.*	50% co-payment	50% co-insurance after deductible
	Vasectomy *See page 23 of UH Summary of Benefits for details.*	$100 co-payment	50% co-insurance after deductible

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)

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)

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Prescribed Medical Services, Supplies, Durable Medical Equipment (DME) and Outpatient Facility ***(Furnished, authorized, or arranged by provider during an office visit)***	Chemotherapy, Radiation Therapy, MRI, PET, CT scan, SPECT Scans, Mammograms, X-Rays and Diagnostic Laboratory Tests. ***Outpatient only. (Chemotherapy has an annual benefit limit of $250,000.)***	No co-payment	30% co-insurance after deductible
	Durable Medical Equipment (Rental or purchase.)	No co-payment	30% co-insurance after deductible
	Breast Pump (A member may obtain a breast pump during their pregnancy or after delivery).	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) **Benefit limit still applies**
	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 (***Limit of $10,000 per occurrence per plan year.)***	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 (***Benefit limit of $2,000 per plan year.)***	No co-payment	30% co-insurance after deductible
Urgent Care *See page 12 of UH Summary of Benefits for Details*	Covered Services Received at an Urgent Care Center	$20 co-payment per visit (UH Express Med Only)	30% co-insurance after deductible

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Emergency Room or Observation Period *See pg. 13 of UH Summary of Benefits for details*	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.	$100 co-payment per visit If hospitalized, ER Co-pay is waived. Hospital inpatient co-pay will apply. **University Hospital Emergency Center is the ONLY emergency room in the UH Network.**	Co-insurance will apply after the deductible is met. If hospitalized, hospital inpatient co-insurance will apply. *See pg. 13 of UH Summary of Benefits for details*
Hospital Inpatient (Authorization required if outside of UH)	All inpatient covered services and supplies, ICU, delivery, oxygen, hospital, ancillary charges, and medications.	$100 co-payment per day (Five-day co-pay max per confinement)	30% co-insurance after deductible
	Newborn Care (48/96-hour delivery stay)	No co-payment	No deductible 30% co-insurance will apply
	Newborn stay beyond the 48/96-hour period	$100 co-payment per day (Five-day co-payment max per confinement)	30% co-insurance after deductible
	Physician's charges, including surgery	No co-payment	30% co-insurance after deductible
Outpatient Surgery (Preauthorization required if outside of UH)	Services and supplies in connection with surgical treatment	No co-payment	30% co-insurance after deductible
	Outpatient Surgery (***Hospital or facility***)	$100 co-payment per visit	30% co-insurance after deductible
	Physician Charges	No co-payment	30% co-insurance after deductible

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Obesity Treatment (Preauthorization Required)	See Coverage Limitations on pages 33 & 40 from the *Summary of Benefits.* **Authorization Required.**	$30,000 Lifetime Maximum All co-payments still apply **All procedures and services must be performed at University Hospital, no other facilities.**	**This treatment is NOT covered under the expanded network.**
Outpatient Therapy 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. ****Outpatient Therapy visits cannot be combined with Home Health Therapy benefits. See Home Health.**	$15 co-payment per visit	30% co-insurance after deductible
Applied Behavioral Analysis Therapy (ABA)	Outpatient Therapy Home Health Visit **Must meet Home Health Visit criteria. See page 25 of UH Certificate of Coverage for benefit details*. ****Home Health visits cannot be combined with outpatient therapies benefit.**	$15 co-payment per visit (No visit limitation with ABA diagnosis) $15 co-payment per visit (No visit limitation with ABA diagnosis) ***See page 25 of UH Summary of Benefits for details.*	30% co-insurance after deductible 30% co-insurance after deductible

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Skilled Nursing Facility	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
Behavioral Health Services (Inpatient & Outpatient)	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
Alcoholism/ Chemical Dependency	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
Hospice	Services furnished by a hospice or hospice team.	No In-Network Benefit	30% co-insurance after deductible
Home Health Care	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. ****Home Health visits cannot be combined with outpatient therapies benefit.**	No co-payment (Total annual limit of 60 visits; per service)	30% co-insurance after deductible.

BENEFIT	***DESCRIPTION***	***CO-PAYMENTS UH NETWORK***	***CO-INSURANCE EXPANDED NETWORK***
Medical Transportation	Emergency ground or air ambulance transportation when medically necessary. **** 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.***	Plan will pay up to $1,500 of the Usual and Customary	Plan will pay up to $1,500 of the Usual and Customary
Vision Services	Comprehensive eye exam (one per year) through Envolve	$10 co-payment per visit	No In-Network Benefit
Other Covered Services	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
Chiropractic Services	Services and supplies furnished in connection with correction, by manual or mechanical means, of subluxation of the spine. Benefit limited to 10 visits per year.	$15 co-payment per visit	30% co-insurance after deductible and up to $75 per visit max

BENEFIT	DESCRIPTION	CO-PAYMENTS UH NETWORK	CO-INSURANCE EXPANDED NETWORK
Schedule of Co-payments for Prescription Medications and Maintenance Medications	Preferred Generic Medications Tier 1	Co-payment waived if filled at a University Health Pharmacy.	$20 (30 day) $40 (90 day)
	Preferred Brand Name Medications and Select Generics Tier 2	Co-payment waived if filled at a University Health Pharmacy.	$40 (30 day) $60 (90 day)
	Non-Preferred Medications or Specialty drugs Tier 3	Co-payment waived if filled at a University Health Pharmacy.	$60 (30 day) $100 (90 day)
	Download the Refill Pro App from your iOS or Android app store.		
Mail Order Prescription Benefit	University Health Pharmacies	No co-payment Prescription must be written by a Licensed Physician. www.universityhealthsystem.com/rxandgo	