



**FAMILY CARE PLAN**  
**FAMILY CARE PLAN EXPANDED NETWORK OPTION**

**SCHEDULE OF BENEFITS, COPAYMENTS AND DEDUCTIBLES**

The following chart shows eligible services and supplies for Your Coverage. The Copayment amounts are shown at the right. If there is no Copayment, the service or supply shown will be covered at 100 percent (UHS Network). Members are responsible for the payment of Copayments 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 Copayments for the balance of the Contract Year (PPO Network). *Copayments for prescription drugs and infertility testing and treatment are not applicable to any annual Out-Of-Pocket maximums.*

Lifetime Benefit Maximum	\$1,000,000 includes both UHS Network and PPO Network	
Annual Deductible	UHS Network	PPO Network
Individual/Family	None	\$500/\$1,000
Annual Out-of-Pocket Maximum(after deductible) Individual/Family	None	\$4,000/\$8,000

**Basic Coverage:**

<b><i>BENEFIT</i></b>	<b><i>DESCRIPTION</i></b>	<b><i>COPAYMENTS UHS NETWORK</i></b>	<b><i>COPAYMENTS PPO NETWORK</i></b>
<b><i>Physician Services</i></b>	Office visits	\$15 per visit	30% copay after deductible
	Inpatient hospital visits	None	30% copay after deductible
	Allergy testing and treatment (sera for food allergies is excluded)	\$15 per visit	30% copay after deductible
	Prenatal visits (after first office visit)	None	30% copay after deductible
<b><i>Preventive Care Services</i></b>  <i>(Furnished, authorized or arranged by a Provider during an office visit)</i>	Well baby care /well child care Pediatric and adult Immunization	\$15 per visit None	30% copay after deductible 30% copay after deductible
	Physical examinations (covered annually)* Mammography services	\$15 per visit None	30% copay after deductible 30% copay after deductible
	<b>*When combined with a Physician Office Visit, only one Copayment will apply.</b>		

<b>BENEFIT</b>	<b>DESCRIPTION</b>	<b>COPAYMENTS UHS NETWORK</b>	<b>COPAYMENTS PPO NETWORK</b>
<b>Family Planning</b>  <i>(Pre-Authorization is required for some Family Planning services)</i>	Office visits	\$15 per visit	30% copay after deductible
	Infertility testing/treatment & Office visit	50% copay	50% copay after deductible
	Infertility Medications	50% copay	50% copay after deductible
	Voluntary sterilization procedures	\$100 copay	30% copay after deductible
<b>Prescribed Medical Services and Supplies</b>  <i>(Furnished, authorized or arranged by provider during an office visit)</i>	Chemotherapy, Radiation therapy, MRI, CT Scan, X-Rays and laboratory tests.	None	30% copay after deductible
	Durable medical equipment (rental or purchase) Subject to a \$2,000 limit per year	None	30% copay after deductible
	Hearing aids, including batteries. Benefit limit of \$500 per year, not per ear.	None	30% copay after deductible
	Disposable and other eligible supplies	15% copay	30% copay after deductible
	Diabetes equipment and supplies.	15% copay	30% copay after deductible
	Prostheses – limit of \$10,000 per occurrence	None	30% copay after deductible
	Implants	None. Inpatient copay applies.	30% copay after deductible
Cochlear implant. Limit of \$500 limit per occurrence	None	30% copay after deductible	
<b>Urgent Care</b>	Covered services received at an Urgent Care Center	\$15 per visit	30% copay after deductible
<b>Emergency Room or Observation Period</b>	Members are required to pay a copay, per visit, at any participating or non-participating facility, if treated and released.  Members may be required to pay bill in full at a non-participating facility and submit the claim to Community First for reimbursement less the copay. Community First will pay for Emergency Care 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.	\$100 per visit Copay is waived if hospitalized	30% copay after deductible

<b><i>BENEFIT</i></b>	<b><i>DESCRIPTION</i></b>	<b><i>COPAYMENTS UHS NETWORK</i></b>	<b><i>COPAYMENTS PPO NETWORK</i></b>
<b><i>Hospital Inpatient (Authorization required)</i></b>  <i>(Copayment required for each period of stays. One period consists of all Related Inpatient Stays)</i>	All inpatient covered services and supplies, ICU, delivery, oxygen, hospital, ancillary charges and medications.	\$100 per day (Five-day copay max per confinement)	30% copay after deductible
	Newborn care	None	None
	Physician's charges, including surgery	None	30% copay after deductible
<b><i>Outpatient Surgery (Preauthorization required)</i></b>	Services and supplies in connection with surgical treatment	None	30% copay after deductible
	Outpatient surgery (hospital or facility)	\$100 per visit	30% copay after deductible
<b><i>Outpatient Therapy</i></b>	Outpatient Therapy Physical Therapy – 20 visit max per year Occupational Therapy – 20 visit max per year Speech and Hearing Therapy – 20 visit max per year Pulmonary Rehabilitation Therapy – 20 visit max per year Cardiac Rehabilitation Therapy – 36 visit max per year.	\$15 per visit	30% copay after deductible
<b><i>Skilled Nursing Facility</i></b>	All covered services and supplies up to 120 days per year, including semi-private room, ancillary charges and medications.	\$15 per day	30% copay after deductible Lifetime maximum of \$10,000.
<b><i>Serious Mental Illness</i></b>	Inpatient covered services and supplies	\$100 per day (Five-day copay max per related inpatient stay)	30% copay after deductible
	Outpatient visits for Serious Mental Illness (60 visit max per year)	\$15 per visit	30% copay after deductible

<b><i>BENEFIT</i></b>	<b><i>DESCRIPTION</i></b>	<b><i>COPAYMENTS UHS NETWORK</i></b>	<b><i>COPAYMENTS PPO NETWORK</i></b>
<b><i>Mental Health Services</i></b>	<p>Outpatient visits for crisis intervention and evaluation (20 visit max per year)</p> <p>Inpatient covered services and supplies (20 day max per year)</p> <p>Residential treatment center for children and adolescents, crisis stabilization unit <b><i>or</i></b></p> <p>Day treatment facility (40 day max per year)</p>	<p>\$15 per visit</p> <p>\$100 per day (Five-day copay max per related inpatient stay)</p> <p>\$15 per visit</p>	<p>30% copay after deductible</p> <p>30% copay after deductible</p> <p>30% copay after deductible</p>
<b><i>Alcoholism/ Chemical Dependency</i></b>	<p>All medically necessary covered services. Limited to a lifetime maximum of 3 separate series of treatment for each covered individual.</p> <p>Inpatient</p> <p>Outpatient</p>	<p>\$100 per day (Five-day copay max per related inpatient stay)</p> <p>\$15 per visit</p>	<p>30% copay after deductible</p> <p>30% copay after deductible</p>
<b><i>Home Health Care</i></b>	<p>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.</p>	<p>None (60 day max per year)</p>	<p>30% copay after deductible. (Lifetime maximum of \$10,000)</p>
<b><i>Medical Transportation</i></b>	<p>Emergency ground or air ambulance transportation when medically necessary</p>	<p>None</p>	<p>30% copay after deductible</p>
<b><i>Vision Services</i></b>	<p>Comprehensive eye exam (one per year)</p>	<p>\$10 per visit</p>	<p>30% copay after deductible</p>
<b><i>Other Covered Services</i></b>	<p>Psychological testing authorized or arranged by a physician.</p> <p>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.</p>	<p>\$15 per visit</p> <p>None</p>	<p>30% copay after deductible</p> <p>30% copay after deductible</p>