



COMMUNITY FIRST HEALTH PLANS

Keeping Our Commitment to You

PPO Benefit Plan Summary*

Plan Option	Coinsurance		Deductible		Maximum Out-of-Pocket Coinsurance per Contract Yr.		Lifetime Maximum	Primary Care Office Visit	Specialist Office Visit
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network			
Overview	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Lifetime Maximum	In Network	In Network
50/50	50%	50%	\$1,000/ \$3,000	\$2,000/ \$6,000	\$5,000/ \$15,000	\$10,000/ \$30,000	\$1,000,000	\$40 Copay Deductible waived	50% after deductible
70/50	70%	50%	\$2,000/ \$6,000	\$4,000/ \$12,000	\$4,000/ \$12,000	\$8,000/ \$24,000	\$1,000,000	\$40 Copay Deductible waived	\$60 Copay Deductible waived
80/70 500	80%	70%	\$500/ \$1,500	\$1,000/ \$3,000	\$1,500/ \$4,500	\$3,000/ \$9,000	\$1,000,000	\$30 Copay Deductible waived	\$50 Copay Deductible waived
80/70 1000	80%	70%	\$1,000/ \$3,000	\$2,000/ \$6,000	\$3,000/ \$9,000	\$6,000/ \$18,000	\$1,000,000	\$30 Copay Deductible waived	\$50 Copay Deductible waived
90/70 500	90%	70%	\$500/ \$1,500	\$1,000/ \$3,000	\$1,500/ \$4,500	\$3,000/ \$9,000	\$1,000,000	\$20 Copay Deductible waived	\$40 Copay Deductible waived
90/70 1000	90%	70%	\$1,000/ \$3,000	\$2,000/ \$6,000	\$1,500/ \$4,500	\$3,000/ \$9,000	\$1,000,000	\$30 Copay Deductible waived	\$50 Copay Deductible waived
90/70 3000	90%	70%	\$3,000/ \$9,000	\$6,000/ \$18,000	\$6,000/ \$18,000	\$12,000/ \$36,000	\$1,000,000	90% after deductible	90% after deductible
90/70 5000	90%	70%	\$5,000/ \$15,000	\$10,000/ \$30,000	\$10,000/ \$30,000	\$20,000/ \$60,000	\$1,000,000	90% after deductible	90% after deductible
100/70 3000	100%	70%	\$3,000/ \$9,000	\$6,000/ \$18,000	\$0	\$12,000/ \$36,000	\$1,000,000	\$30 Copay Deductible waived	\$50 Copay Deductible waived
100/70 5000	100%	70%	\$5,000/ \$15,000	\$10,000/ \$30,000	\$0	\$20,000/ \$60,000	\$1,000,000	\$30 Copay Deductible waived	\$50 Copay Deductible waived

*Community First Group Hospital Service Corporation

HMO Benefit Plan Summary

Plan Option	Coinsurance	Deductible		Maximum Out-of-Pocket		Lifetime Maximum	PCP Office Visit	Specialist Office Visit
		Individual	Family	Individual	Family			
HMO Classic Plan	N/A	None		Individual \$3,000	Family \$6,000	N/A	\$30 Copay	\$50 Copay
HMO Share Plan	Plan: 80% Member: 20% (Network Providers Only)	Individual \$1,000	Family \$3,000	Individual \$5,000	Family \$10,000	\$1,000,000	\$40 Copay Deductible waived	\$60 Copay After deductible
HMO First Plan	Coinsurance will apply for stated services.	Individual \$1,000	Family \$3,000	Individual \$4,000	Family \$12,000	\$1,000,000	\$40 Copay Deductible waived	\$60 Copay After deductible

Our standard prescription drug benefit is 15/40/75 for a 30 day supply.

12238 Silicon Drive, Suite 100 • San Antonio, TX 78249

www.CFHP.com • Main Office: (210) 227-CFHP (2347) • Toll-Free: (800) 434-CFHP (2347)