Health First Health Plans : LG HD HMO 1500/80 w Co-pays 6002

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: On or after 12/01/2014
Coverage for: Members Only | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myHFHP.org or by calling 1-855-443-4735.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$1,500** person/**$3,000** family Does not apply to in-network preventive services., Copays do not contribute.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	Yes. For participating providers **$4,500** person/**$9,000** family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums and non-covered services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of participating providers see www.myHFHP.org or call 1-855-443-4735.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not Covered	See plan provisions for details.
	Specialist visit	$45 copay/visit	Not Covered	See plan provisions for details.
	Other practitioner office visit	Chiropractor/Podiatrist: $30 copay per visit	Not Covered	Chiropractor-maximum of 20 visits per calendar year.
	Preventive care/screening/immunization	$0 copay	Not Covered	See plan provisions for details.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay-diagnostic labs; 20% coinsurance after deductible-x-rays	Not Covered	See plan provisions for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not covered	Requires authorization. See plan provisions for details.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myHFHP.org	Preferred Generic drugs	$1 - $2 or 50%	N/A	See plan provisions for details.
	Non-Preferred Generic drugs	$5 - $15 or 50%	N/A	See plan provisions for details.
	Preferred brand drugs	$10 - $50, 50%, or $15 + 20%	N/A	See plan provisions for details.
	Non-preferred brand drugs	$30 - $150, 50%, or $20 + 30%	N/A	See plan provisions for details.
	Specialty drugs	$60 - $100 , 20% - 50%, or $40 + 30%	N/A	See plan provisions for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$650 copay	Not Covered	See plan provisions for details.
	Physician/surgeon fees	$0 copay	Not Covered	See plan provisions for details.
If you need immediate medical attention	Emergency room services	$300 copay, first visit; then $500 copay per visit, remainder of calendar year.	$300 copay, first visit; then $500 copay per visit, remainder of calendar year.	See plan provisions for details.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	See plan provisions for details.
	Urgent care	$75 copay/visit	Not covered	Outside the service area, coverage is provided at a non-participating urgent care center or licensed physician office. Within the service area, coverage is only provided at a participating urgent care center or licensed physician office. See plan provisions

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	See plan provisions for details.
	Physician/surgeon fee	20% coinsurance after deductible	Not Covered	See plan provisions for details.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay per visit	Not covered	See plan provisions for details.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Not covered	See plan provisions for details.
	Substance use disorder outpatient services	$45 copay per visit	Not covered	See plan provisions for details.
	Substance use disorder inpatient services	20% coinsurance after deductible	Not Covered	See plan provisions for details.
If you are pregnant	Prenatal and postnatal care	$45 copay per visit /$45 copay per ultrasound image.	Not covered	See plan provisions for details.
	Delivery and all inpatient services	20% coinsurance after deductible	Not covered	See plan provisions for details.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	60 visits per year. See plan provisions for details.
	Rehabilitation services	20% coinsurance after deductible	Not covered	Some therapies require authorization. See plan provisions for details.
	Habilitation services	Not covered	Not covered	See plan provisions for details.
	Skilled nursing care	20% coinsurance after deductible	Not covered	120 days maximum per year. See plan provisions for details.
	Durable medical equipment	20% coinsurance after deductible	Not covered	See plan provisions for details.
	Hospice service	20% coinsurance after deductible	Not covered	For inpatient, outpatient, or combined, 180 days max/calendar year. See plan provisions for details.
If your child needs dental or eye care	Eye exam	Included in well-child exams.	Not covered	Limits apply. See plan provisions for details.
	Glasses	Not covered	Not covered	See plan provisions for details.
	Dental check-up	Not covered.	Not covered.	See plan provisions for details

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic services (limited)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-443-4735. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Health First Health Plans Customer Service (weekdays 8am to 5pm)
Phone Toll-Free: (855) 443-4735
TDD services for the hearing or speech impaired: (800) 955-8771
Fax Number: (855) 328-0062

Health First Health Plans Attn: Member Advocate
6450 US Highway 1 Rockledge, FL 32955
www.myHFHP.org
hfhpinfo@hf.org

Agency for Health Care Administration (AHCA)
Call 1-888-419-3456. (fully-insured plans only)

Florida's Office of Insurance Regulation (OIR)
Call 1-877-693-5236. (fully-insured plans only)

Employee Benefits Security Administration
Call 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

We offer this plan information in alternative languages. Please contact customer service at 1-855-443-4735.
Para obtener asistencia en Español, llame al 1-855-443-4735.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
Plan pays $4,520
Patient pays $3,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,500
Copays	$780
Coinsurance	$590
Limits or exclusions	$150
Total	$3,020

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
Plan pays $3,270
Patient pays $2,130

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,270
Copays	$780
Coinsurance	$0
Limits or exclusions	$80
Total	$2,130

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-800-308-5848.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.