Health First Health Plans

Underwritten by Health First Commercial Plans

# Health First GYM ACCESS Silver AV87 POS

## 80 1299

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

**Coverage Period: On or after 01/01/2017**

**Coverage for: Members Only | Plan Type: POS**

**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 http://www.myHFHP.org/COC_HI_2017 or by calling 1.855.443.4735.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible**? | **$500** person/ **$1,000** family in network; **$6,200** person/ **$12,400** family out of network Does not apply to in-network preventive services., Copays, balance billed charges 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? | Prescription drugs_ **$250** person/**$500** family | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an **out–of–pocket limit** on my expenses? | Yes. For participating providers **$1,250** person/**$2,500** family For non-participating providers **$12,100** person/**$24,200** 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, balance billed charges, 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 http://www.myHFHP.org/MP_directory_2017 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. |

**Questions:** Call 1.855.443.4735 or visit us at www.myHFHP.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.myHFHP.org/SBC or call 1.855.443.4735 to request a copy.

- **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 | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Specialist visit | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Other practitioner office visit | 20% coinsurance after deductible | 30% coinsurance after deductible | Chiropractor-maximum of 26 visits per calendar year. |
| | Preventive care/screening/immunization | $0 copay | 30% coinsurance after deductible | You may have to pay for services that aren't preventive. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 30% coinsurance after deductible | See section IV and V of plan document |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |

| 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<br><br>More information about **prescription drug coverage** is available at http://www.myHFHP.org/MP_formulary_2017 | Preferred Generic drugs | $2 copay, retail or mail order | N/A | Copay is for 30 day supply. |
| | Non-Preferred Generic drugs | $15 copay, retail or mail order | N/A | Copay is for 30 day supply. |
| | Preferred brand drugs | $250/$500 deductible, then $30 copay for 30 day supply | N/A | Cost share is for retail, mail order |
| | Non-preferred brand drugs | $250/$500 deductible, then $50 copay for 30 day supply | N/A | Cost share is for retail, mail order |
| | Specialty drugs | 30% after deductible | N/A | 30 day supply only. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | Authorization may be required. |
| If you need immediate medical attention | Emergency room services | 20% coinsurance after deductible | 20% coinsurance after deductible | See section IV and V of plan document |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | See section IV and V of plan document |
| | Urgent care | 20% coinsurance after deductible | 30% coinsurance after deductible | See section IV and V of plan document |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 30% coinsurance after deductible | Limit 21 days per year for inpatient rehabilitative services. Authorization required. |
| | Physician/surgeon fee | 20% coinsurance after deductible | 30% coinsurance after deductible | Authorization may be required. |

| 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 mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| | Mental/Behavioral health inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| | Substance use disorder outpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| | Substance use disorder inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Authorization required. |
| If you are pregnant | Prenatal and postnatal care | $0 per visit 1-15; ultrasounds 20% coinsurance after deductible. | 30% coinsurance after deductible | In network visit 16+ subject to Specialist cost share. |
| | Delivery and all inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance after deductible | 30% coinsurance after deductible | Limit 60 visits per year. |
| | Rehabilitation services | 20% coinsurance after deductible | 30% coinsurance after deductible | 20 hours per year, per condition. Requires authorization. |
| | Habilitation services | 20% coinsurance after deductible | 30% coinsurance after deductible | 20 hours per year, per condition. Requires authorization. |
| | Skilled nursing care | 20% coinsurance after deductible | 30% coinsurance after deductible | 60 days maximum per year. Requires authorization. |
| | Durable medical equipment | 20% coinsurance after deductible | 30% coinsurance after deductible | Authorization may be required. |
| | Hospice service | 20% coinsurance after deductible | 30% coinsurance after deductible | 180 day maximum/calendar year |
| If your child needs dental or eye care | Eye exam | $0 copay | Not covered. | One routine eye exam per year. |
| | Glasses | $0 copay | Not covered. | One pair of eyeglasses (frame and basic lenses) per year. |
| | Dental check-up | $0 copay | Not covered. | See plan provision materials 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.)**

- Abortion, except in cases of rape, incest, or jeopardized health of the mother
- 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.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855.443.4735.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844.552.5279.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844.552.5279.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844.552.5279.

*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** $6,140
**Patient pays** $1,400

**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 | $500 |
| Copays | $0 |
| Coinsurance | $750 |
| Limits or exclusions | $150 |
| Total | $1,400 |

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

**Amount owed to providers:** $5,400
**Plan pays** $4,360
**Patient pays** $1,040

**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 | $500 |
| Copays | $80 |
| Coinsurance | $380 |
| Limits or exclusions | $80 |
| Total | $1,040 |

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.

**English:**
If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

**Spanish:**
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

**Haitian Creole:**
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

**Vietnamese:**
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

**Portuguese:**
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

**Chinese:**
如果您，或是您正在協助的對象，有與 Health First Health Plans 相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

**French:**
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

**Tagalog:**
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

**Russian:**
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

**Arabic:**
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

**Italian:**
Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

**German:**
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

**Korean:**
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735로 전화하십시오.

**Polish:**
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

**Gujarati:**
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હેલ્થ ફર્સ્ટ હેલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કૉલ કરો.

**Thai:**
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plans คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.

## Nondiscrimination Notice

Health First Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health First Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Doris Garcia-Durand.

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Doris Garcia-Durand, ADA/Section 504 Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, doris.garciadurand@hf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Doris Garcia-Durand, ADA/Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.