Health First Health Plans

Underwritten by Health First Commercial Plans

# Health First Access 5000 POS 6179

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period: On or after 01/01/2019**

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

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, myHFHP.org/COC_HLA_2019 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-443-4735 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible**? | **$5,000** person/ **$10,000** family in network; **$10,000** person/ **$20,000** family out of network | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your **deductible**? | In-network: preventive services, maternity office visits (1-15 per year) | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventative-care-benefits/. |
| Are there other **deductibles** for specific services? | No, There are no other specific deductibles. | No, you don't have to meet deductibles for specific services. |
| What is the **out-of- pocket limit** for this plan? | $6,350 person/ $12,700 family in network;; $20,000 person/ $30,000 family out of network | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met |
| 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 |
| Will you pay less if you use a **network provider**? | Yes. See www.myHFHP.org or call 1.855.443.4735 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do I need a **referral** to see a **specialist**? | No. | You can see the specialist you choose without a referral |



All **copayments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you visit a health care **provider's** office or clinic | Primary care visit to treat an injury or illness | $20 copay | 30% coinsurance after deductible | None |
| | **Specialist** visit | $40 copay | 30% coinsurance after deductible | None |
| | **Preventive care** / **screening** /immunization | $0 copay | 30% coinsurance after deductible | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | **Diagnostic test** (x-ray, blood work) | $0 copay-diagnostic labs; 20% coinsurance after deductible_x-rays | 30% coinsurance after deductible | See section IV and V of plan document |
| | Imaging (CT/PET scans, MRIs) | $250 copay | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at www.myHFHP.org/MP_formulary_2019 | Preferred Generic drugs | $2 - $10 per 30 day supply | N/A | Copay is for 30 day supply. |
| | Non-Preferred Generic drugs | $5 - $50 per 30 day supply | N/A | Copay is for 30 day supply. |
| | Preferred brand drugs | $10 - $100 or deductible | N/A | Cost share is for retail, mail order |
| | Non-preferred brand drugs | $30-$150 or deductible | N/A | Cost share is for retail, mail order |
| | Specialty drugs | $60-$100 or 20% | 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 | $150 copay | $150 copay | See section IV and V of plan document |
| | Urgent care | $50 copay | 30% coinsurance after deductible | See section III.D of plan document for details. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $250 copay per day, days 1-5 | 30% coinsurance after deductible | Authorization required. |
| | Physician/surgeon fee | $0 copay | 30% coinsurance after deductible | Authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $20 copay | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| | Inpatient services | $250 copay/day, days 1-5 | 30% coinsurance after deductible | Requires authorization, without which uncovered expenses might become member's responsibility |
| If you are pregnant | Office visits | $0 per visit 1-15; ultrasounds $25 copay | 30% coinsurance after deductible | In network visit 16+ subject to Specialist cost share. |
| | Childbirth/delivery professional services | $0 copay | 30% coinsurance after deductible | Authorization required. |
| | Delivery and all inpatient services | $250 copay/day, days 1-5 | 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 | $0 copay | 30% coinsurance after deductible | Limit 60 visits per year. |
| | Rehabilitation services | $20 copay | 30% coinsurance after deductible | 20 visits per year, per condition. |
| | Habilitation services | $20 copay | 30% coinsurance after deductible | 20 visits per condition per year. Limited to treatment of Down syndrome, Autism Spectrum Disorder. |
| | Skilled nursing care | $250 copay/day, days 1-5 | 30% coinsurance after deductible | 120 days maximum per year. |
| | Durable medical equipment | 20% coinsurance after deductible | 30% coinsurance after deductible | Authorization may be required. |
| | Hospice service | $250 copay/day, days 1-5 inpatient; $20 copay outpatient | 30% coinsurance after deductible | See section IV and V of plan document |
| If your child needs dental or eye care | Children's eye exam | Included in well child exam | Not covered. | See section IV and V of plan document |
| | Children's glasses | Not covered | Not covered. | See section V of plan document |
| | Children's dental check-up | Not covered | Not covered. | See section V of plan document\|1\|1 |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion, except in cases of rape, incest, or jeopardized health of the mother
- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care
- Dental care (adult)
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic services (limited)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the **explanation of benefits** you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim appeal** or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, 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 plan provide Minimum Essential Coverage?** **This plan or policy Does provide minimum essential coverage.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** **This health coverage Does meet the minimum value standard for the benefits it provides.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## 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:



**This is not a cost estimator.** Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost sharing amounts (**deductibles** , **copayments** and **coinsurance**) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | $5,000 |
| **Specialist [cost sharing]** | copayment $40 |
| **Hospital (facility) [cost sharing]** | copayment $250 |
| **Other coinsurance** | coinsurance 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *( prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *( ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | $11,500 |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $800 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $1,000 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | $5,000 |
| **Specialist [cost sharing]** | copayment $40 |
| **Hospital (facility) [cost sharing]** | copayment $250 |
| **Other coinsurance** | coinsurance 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | $7,400 |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $1,600 |
| Coinsurance | $70 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | $2,000 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | $5,000 |
| **Specialist [cost sharing]** | copayment $40 |
| **Hospital (facility) [cost sharing]** | copayment $250 |
| **Other coinsurance** | coinsurance 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | $1,900 |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,300 |

# 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 our Civil Rights Coordinator.

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: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@hf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights 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*.