Health First Health Plans : SG Choice SILVER 70-6 High Deductible Health Plan

Coverage Period: On or after 01/01/2014

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

Coverage for: Members Only | Plan Type: PPO

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.HealthFirstHealthPlans.org or by calling 1-800-716-7737.

Important Questions	Answers	Why this Matters:
What is the overall **deductible** ?	**$2,000** person/**$4,000** family in **network** **$4,000** person/**$8,000** family out of network Does not apply to preventive services., **Copays** balance billed charges do not contribute., Prescription drugs_ **$200** **deductible** on brand	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** **$4,600** person/**$9,200** family For non-participating **providers** **$9,200** person/**$18,400** 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 www.HealthFirstHealthPlans.org or call 1-800-716-7737.	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 1-800-716-7737 or visit us at www.HealthFirstHealthPlans.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 http://www.HealthFirstHealthPlans.org/SBC or call 1-800-716-7737 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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Specialist visit	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Other practitioner office visit	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	Chiropractor-26 visits/benefit period
	Preventive care/screening/immunization	$0 copay	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Imaging (CT/PET scans, MRIs)	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	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.HealthFirstHealthPlans.org	Preferred Generic drugs	$2 per 30 day supply; $6 per 90 day supply	N/A	See plan provisions for details.
	Non-Preferred Generic drugs	$15 per 30 day supply; $45 per 90 day supply	N/A	See plan provisions for details.
	Preferred brand drugs	$200 deductible, then $30 copay for 30 day supply or $90 copay for 90 day supply	N/A	See plan provision for details.
	Non-preferred brand drugs	$200 deductible, then $50 copay for 30 day supply only.	N/A	See plan provisions for details.
	Specialty drugs	$200 deductible, then 30%	Not covered.	30 day supply through Health First Family Pharmacy only. See plan provisions for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Physician/surgeon fees	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
If you need immediate medical attention	Emergency room services	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	See plan provisions for details.
	Emergency medical transportation	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Urgent care	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	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 have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Physician/surgeon fee	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay,then 50% deductible	Deductible, then 50% coinsurance plus balance billed charges.	Services, plus others, apply to 4 office visit **copay** total limit/ year
	Mental/Behavioral health inpatient services	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Substance use disorder outpatient services	$50 copay,then 50% deductible	Deductible, then 50% coinsurance plus balance billed charges.	Services, plus others, apply to 4 office visit **copay** total limit/ year
	Substance use disorder inpatient services	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
If you are pregnant	Prenatal and postnatal care	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Delivery and all inpatient services	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
If you need help recovering or have other special health needs	Home health care	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	60 visit maximum per benefit period. See plan provisions for details.
	Rehabilitation services	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Habilitation services	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	20 hours per calendar year, per condition. Authorization required. See plan provisions for details.
	Skilled nursing care	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	120 days maximum per benefit period. See plan provisions for details.

	Durable medical equipment	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Hospice service	Deductible, then 30% coinsurance	Deductible, then 50% coinsurance plus balance billed charges.	180 days max/calendar year. See plan provisions for details.
If your child needs dental or eye care	Eye exam	$0 copay	Deductible, then 50% coinsurance plus balance billed charges.	See plan provisions for details.
	Glasses	$0 copay	Deductible, then 50% coinsurance plus balance billed charges.	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	• Hearing aids	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine eye care
• Cosmetic surgery	• Long-term care	• Routine food care
• Dental care	• Non-emergency care when traveling outside the U.S.	• 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 1-800-716-7737. 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 8pm)
Phone: (321) 434-5665 / Toll-Free: (800) 716-7737
TDD services for the hearing or speech impaired: (800) 955-8771
Fax Number: (321) 434-4769

Health First Health Plans Attn: Member Advocate
6450 US Highway 1 Rockledge, FL 32955
www.healthfirsthealthplans.org
hfhpinfo@health-first.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 1-800-716-7737.
Para obtener asistencia en Español, llame al 1-800-716-7737.

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 $3,810
Patient pays $3,730

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	$2,000
Copays	$0
Coinsurance	$1,580
Limits or exclusions	$150
Total	$3,730

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

Amount owed to providers: $5,400
Plan pays $3,110
Patient pays $2,290

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	$2,000
Copays	$80
Coinsurance	$130
Limits or exclusions	$80
Total	$2,290

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.