About this Schedule of Benefits
This Schedule of Benefits outlines the cost-shares (such as deductibles, copayments and coinsurance) that apply to covered services under your plan. It is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. If this Schedule of Benefits conflicts in any way with the Certificate of Coverage (contract), the contract shall prevail. Please review your contract for a description of services, supplies, terms and conditions of coverage.

For multiple outpatient services received on the same date of service, more than one cost-share may apply, unless expressly stated otherwise herein. For example, if you receive an injection in your physician’s office, you may be responsible for the cost-share associated with a physician visit and the cost-share associated with practitioner-administered medications under this plan.

How to contact us for help
For assistance regarding information about coverage, questions or complaints, please call Customer Service toll-free at 1.855.443.4735. You may also log onto your secure member portal at myHFHP.org/login.
# Health First 6600/100 HMO 6020
## SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>MEMBER COST-SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Calendar Year Deductible</strong> (Per Individual/Family)</td>
<td>$6,600/$13,200</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket Expense Limit</strong> (Per Individual/Family)</td>
<td>$6,600/$13,200</td>
</tr>
</tbody>
</table>

### COVERED SERVICES\(^1\)

**OUTPATIENT SERVICES AND SUPPLIES**

Authorization rules may apply. Access your member portal at [myHFHP.org/login](http://myHFHP.org/login) to view the Authorization List.

1. **Preventive Care Services**
   Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines. See [HealthCare.gov](http://HealthCare.gov) for the current list of covered preventive services.
   - **Preventive Care Services**
   - **Primary Care Physician Office Visit**
     - **Primary Care Physician Office Visit**
     - **Specialist Office Visit**
     - **Chiropractic Services**
       - 20 visits maximum per calendar year
     - **Podiatry Services**
     - **Diabetic Retinopathy Screening**
       - Coverage is limited to one screening per calendar year for covered persons with diabetes. Additional vision services are not included.
   - **Prenatal/Postnatal Office Visit** (not including perinatology)
     - Up to 15 visits per calendar year are covered without cost-sharing in-network. Additional visits are subject to the appropriate physician office visit cost-share.
   - **Urgent Care Clinic Visit**
     - **Urgent Care Clinic Visit**
   - **Diagnostic Lab Services** (e.g., blood work)
     - Includes independent clinical labs. Does not include genetic testing.

---

Health First 6600_100 HMO 6020 (1_2020)
<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEMBER COST-SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Testing Lab Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Radiology Services (Per visit, per type)</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services.</td>
<td></td>
</tr>
<tr>
<td>Maternity Ultrasounds</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Advanced Imaging Services (Per visit, per type)</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>CT, MRI, MRA, PET and Nuclear Studies</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing and Immunotherapy (Per visit)</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Includes allergy injections administered by a health care provider.</td>
<td></td>
</tr>
<tr>
<td>Practitioner-Administered Medications</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections and other medications ordered and administered by a provider.</td>
<td></td>
</tr>
<tr>
<td>Physician Office Drug Administration Fee</td>
<td>$0</td>
</tr>
<tr>
<td>Radiation Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Other Diagnostic and Therapeutic Tests and Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgery – Facility Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Includes outpatient hospital &amp; Ambulatory Surgery Center.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery – Physician/Surgeon Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Includes outpatient hospital &amp; Ambulatory Surgery Center.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Observation (Per stay)</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>
### COVERED SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment, Orthotics, &amp; Prosthetic Devices</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>60 visits maximum per calendar year</td>
<td></td>
</tr>
<tr>
<td>Outpatient Physical, Speech and Occupational Therapies</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>20 visits maximum per calendar year for each condition being treated</td>
<td></td>
</tr>
<tr>
<td>Cardiac &amp; Pulmonary Rehabilitation</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.)</td>
<td></td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Hospice Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>All Other Medically Necessary Outpatient Services</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>

### INPATIENT MEDICAL SERVICES

Authorization rules may apply. Access your member portal at [myHFHP.org/login](http://myHFHP.org/login) to view the Authorization List.

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Facility Services (Per admission)</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Inpatient Physician and Surgical Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Skilled Nursing Facility Services (Per admission)</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>120 days maximum per calendar year</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospice Services</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH SERVICES

Authorization rules may apply. Access your member portal at [myHFHP.org/login](http://myHFHP.org/login) to view the Authorization List.

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health Care (Per admission)</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>
# Health First 6600/100 HMO 6020
## SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEMBER COST-SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partial Hospitalization</strong></td>
<td>A structured program of active treatment for psychiatric care that is more intense than the care performed in a physician’s or therapist’s office.</td>
</tr>
<tr>
<td><strong>Mental Health Care Office Visit</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Substance Abuse (Per admission)</strong></td>
<td>Detoxification and acute care only for alcohol/substance abuse</td>
</tr>
<tr>
<td><strong>Substance Abuse Office Visit</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Services</strong></td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL BENEFITS

| Fitness Center Membership                 | $0                                      |

### PRESCRIPTION DRUG BENEFIT

Included in a separate Prescription Drug Rider to be attached if applicable.

---

1 Covered services are subject to limitations, exclusions and plan provisions listed in the Certificate of Coverage.
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).


Health First Health Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.
English:
This Notice has Important Information. This notice has important information about your application or coverage through Health First Health Plans. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 855-443-4735.

Spanish:
Este Aviso contiene información importante. Este aviso contiene información importante acerca de la solicitud o cobertura que usted tiene con Health First Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 855-443-4735.

Haitian Creole:
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a gen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Health First Health Plans. Chèche dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk ak.syoun avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 855-443-4735.

Vietnamese:
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình Health First Health Plans của Quý vị. Xin xem các ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng những hạn độ đặc biệt hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 855-443-4735.

Portuguese:
Este aviso contém informações importantes. Este aviso contém informações importantes a respeito da sua solicitação ou cobertura por meio dos Health First Health Plans. Consulte datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a sua cobertura de plano de saúde ou ajuda com custos. Você tem o direito de obter estas informações e ajuda no seu idioma e sem custos. Ligue para 855-443-4735.

Chinese:
本通知包含重要的資訊。本通知包含關於您透過 Health First Health Plans提交的申請或保險的重要資訊。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權以您的母語免費取得本資訊及幫助。請撥電話 855-443-4735。

French:
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire Health First Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût.Appelez 855-443-4735.
Gujarati:
આ સૂચનામાં અગાઉની માહતી છે. આ સૂચનામાં તેમાં કેટલી કોઈ વિમાનની ફંક્શનગતિ લાઇનાર કરી છે. આ સૂચનામાંની સામાન્ય બાબતો જુઓ. તમારા આરેખા કપાડોને આવી રાખવા અયુધા અંગે મદદ માટે કોઈ વસ્તુઓ સમયમયા સુધીમાં તમારી કાર્યોની કરવાની જરૂર પડી શકે છે. તમને આ માહતી અને મદદ તમારી ભાષામાં વૈના મુલની મેળવવાનો અધિકાર છે. 855-443-4735 પર કોલ કરો.

Thai:
ประกาศนี้ข้อมูลสำคัญ ประกาศนี้ข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตการประกันสุขภาพของคุณผ่าน Health First Health Plans โปรดดูกำหนดการสำคัญในประกาศนี้ คุณอาจต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายจ่ายคุณมีสิทธิ์ที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 855-443-4735.