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.
## PLAN FEATURES

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Calendar Year Deductible</strong> (Per Individual/Family)</td>
<td>$500/$1,000</td>
<td>$1,000/$2,000</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket Expense Limit</strong> (Per Individual/Family)</td>
<td>$3,000/$6,000</td>
<td>$6,000/$12,000</td>
</tr>
<tr>
<td><strong>Out-of-Network Fee Schedule</strong></td>
<td>N/A</td>
<td>Health First Allowable Fee Schedule</td>
</tr>
</tbody>
</table>

### MEMBER COST-SHARE

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>$0</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines. See HealthCare.gov for the current list of covered preventive services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Physician Office Visit</strong></td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$40</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>20 visits maximum per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Diabetic Retinopathy Screening</strong></td>
<td>$0</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Coverage is limited to one screening per calendar year for covered persons with diabetes. Additional vision services are not included.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal/Postnatal Office Visit</strong></td>
<td>$0</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>(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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Clinic Visit</strong></td>
<td>$50</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>

### COVERED SERVICES

#### 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.

- Preventive Care Services
  - Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines.
  - See HealthCare.gov for the current list of covered preventive services.
- 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.
# SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>MEMBER COST-SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing.</td>
<td>$0</td>
</tr>
<tr>
<td>Genetic Testing Lab Services</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Radiology Services (Per visit, per type) Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services.</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Maternity Ultrasounds</td>
<td>$25</td>
</tr>
<tr>
<td>Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies</td>
<td>$250</td>
</tr>
<tr>
<td>Allergy Testing and Immunotherapy (Per visit) Includes allergy injections administered by a health care provider.</td>
<td>$10</td>
</tr>
<tr>
<td>Practitioner-Administered Medications 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>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Physician Office Drug Administration Fee</td>
<td>Deductible then Coinsurance</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 Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgery – Facility Services Includes outpatient hospital &amp; Ambulatory Surgery Center.</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital &amp; Ambulatory Surgery Center.</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>
## Health First Access 500 POS 6169
### SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>COVERED SERVICES1</th>
<th>In-Network</th>
<th>Out-of-Network2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Observation</strong> (Per stay)</td>
<td>$250</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Orthotics, &amp; Prosthetic Devices</strong></td>
<td>Deductible then Coinsurance</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Home Health Care</strong>&lt;br&gt;60 visits maximum per calendar year</td>
<td>$0</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Physical, Speech and Occupational Therapies</strong>&lt;br&gt;20 visits maximum per calendar year for each condition being treated</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Cardiac &amp; Pulmonary Rehabilitation</strong>&lt;br&gt;Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.)</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Hyperbaric Oxygen Therapy</strong></td>
<td>$50</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Deductible then Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospice Services</strong></td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>All Other Medically Necessary Outpatient Services</strong></td>
<td>Deductible then Coinsurance</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>COVERED SERVICES1</th>
<th>In-Network</th>
<th>Out-of-Network2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Facility Services</strong> (Per admission)</td>
<td>$250/day, days 1 – 5; $0, days 6+</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Physician and Surgical Services</strong></td>
<td>$0</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Services</strong> (Per admission)&lt;br&gt;120 days maximum per calendar year</td>
<td>$250/day, days 1 – 5; $0, days 6+</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Hospice Services</strong></td>
<td>$250/day, days 1 – 5; $0, days 6+</td>
<td>Deductible then Coinsurance</td>
</tr>
</tbody>
</table>
# Health First Access 500 POS 6169
## SCHEDULE OF BENEFITS

### COVERED SERVICES\(^1\)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization rules may apply. Access your member portal at <a href="http://myHFHP.org/login">myHFHP.org/login</a> to view the Authorization List.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental Health Care (Per admission)</td>
<td>$250/day, days 1 – 5; $0, days 6+</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Care Office Visit</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Mental Health Services</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Inpatient Substance Abuse (Per admission)</td>
<td>$250/day, days 1 – 5; $0, days 6+</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Detoxification and acute care only for alcohol/substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Office Visit</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Services</td>
<td>$20</td>
<td>Deductible then Coinsurance</td>
</tr>
<tr>
<td><strong>Additional Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitness Center Membership</td>
<td>$0</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Prescription Drug Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included in a separate Prescription Drug Rider to be attached if applicable.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

\(^2\) In addition to the member cost-share, covered persons who receive non-emergent services out-of-network shall be responsible for the difference between the non-participating provider’s charge and our out-of-network allowance.
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).

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 aksyon aven 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 trong thời hạn để duy trì bảo hiểm sức khỏe 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:
Tagalog:
Ang Paunawa na ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa Health First Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan kang magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagkakasaklaw sa kalusugan o makatulong sa mga gastusin. May karapatan kang makuha ang impormasyon at tulong na ito sa iyong wika nang libre. Tumawag sa 855-443-4735.

Russian:
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Health First Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 855-443-4735.

Arabic:
تحوي هذا الإشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Health First Health Plans. إن تحتاج لإتخاذ إجراء في تواريخ معينة للحفاظ على تغطياتك الصحية أو المساعدة في دفع التكاليف. إن الحق في الحصول على معلومات ومساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 855-443-4735.

Italian:
Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti sulla sua domanda o copertura attraverso Health First Health Plans. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una scadenza determinata per consentirle di mantenere la sua copertura o sovvenzione. Ha il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiami il numero 855-443-4735.

German:

Korean:
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Health First Health Plans을 통한 보장에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 확인하십시오. 귀하는 건강 보장을 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 855-443-4735로 전화하십시오.

Polish:
Gujarati:
આ સૂચનામાં અગતયની માહતી છે. આ સૂચનામાં હાલ સુધીમાં કલાકૃત પ્રકારની વિશેની અગતયની માહતી છે. આ સૂચનામાંની પાસ તારીફી કુલભૂત તમારી અરજની અથવા કવરજ કમિશનલા સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા તમારા અરજની અથવા કલાકૃત સારા. 855-443-4735 પર કોલ કરો.

Thai:
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตการประกันสุขภาพของคุณผ่าน Health First Health Plans โปรดดูกำหนดการสำคัญในประกาศนี้
คุณอาจต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย
คุณมีสิทธิ์ที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่มีค่าใช้จ่าย โปรด 855-443-4735.