HMO Large Group
Schedule of Benefits

Provided by:

Health Plans

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 Plans

Health First HF4 HMO 6030
SCHEDULE OF BENEFITS

PLAN FEATURES	
Medical Calendar Year Deductible (Per Individual/Family)	$0
Coinsurance	20%
Maximum Out-of-Pocket Expense Limit (Per Individual/Family) Includes medical and pharmacy expenses per calendar year.	$4,000/$8,000
COVERED SERVICES[1]	**MEMBER COST-SHARE**
OUTPATIENT SERVICES AND SUPPLIES Authorization rules may apply. Access your member portal at 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.	$0
Primary Care Physician Office Visit	$20
Specialist Office Visit	$40
Chiropractic Services 20 visits maximum per calendar year	$20
Podiatry Services	$20
Diabetic Retinopathy Screening Coverage is limited to one screening per calendar year for covered persons with diabetes. Additional vision services are not included.	$0
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.	$0
Urgent Care Clinic Visit	$30
Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing.	$0

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COVERED SERVICES[1]	MEMBER COST-SHARE
Genetic Testing Lab Services	Deductible then Coinsurance
Radiology Services (Per visit, per type) Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services.	Deductible then Coinsurance
Maternity Ultrasounds	$25
Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies	$100
Allergy Testing and Immunotherapy (Per visit) Includes allergy injections administered by a health care provider.	$10
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.	$40
Physician Office Drug Administration Fee	$0
Radiation Services	$40
Dialysis Services	$0
Other Diagnostic and Therapeutic Tests and Services Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits	$0
Emergency Room Visit (Copayment waived if admitted)	$200
Outpatient Surgery – Facility Services Includes outpatient hospital & Ambulatory Surgery Center.	$250
Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital & Ambulatory Surgery Center.	$0
Outpatient Observation (Per stay)	$250

Health Plans

Underwritten by Health First Commercial Plans

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COVERED SERVICES[1]	MEMBER COST-SHARE
Durable Medical Equipment, Orthotics, & Prosthetic Devices	Deductible then Coinsurance
Home Health Care 60 visits maximum per calendar year	$0
Outpatient Physical, Speech and Occupational Therapies 20 visits maximum per calendar year for each condition being treated	$20
Cardiac & Pulmonary Rehabilitation Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.)	$20
Hyperbaric Oxygen Therapy	$20
Ambulance Services	$200
Outpatient Hospice Services	$0
All Other Medically Necessary Outpatient Services	$0
INPATIENT MEDICAL SERVICES Authorization rules may apply. Access your member portal at myHFHP.org/login to view the Authorization List.	
Inpatient Hospital Facility Services (Per admission)	$200/day, days 1 – 5 $0, days 6+
Inpatient Physician and Surgical Services	$0
Skilled Nursing Facility Services (Per admission) 120 days maximum per calendar year	$200/day, days 1 – 5 $0, days 6+
Inpatient Hospice Services	$200/day, days 1 – 5 $0, days 6+
BEHAVIORAL HEALTH SERVICES Authorization rules may apply. Access your member portal at myHFHP.org/login to view the Authorization List.	
Inpatient Mental Health Care (Per admission)	$200/day, days 1 – 5 $0, days 6+

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COVERED SERVICES[1]	MEMBER COST-SHARE
Partial Hospitalization 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.	$20
Mental Health Care Office Visit	$20
Outpatient Mental Health Services	$20
Inpatient Substance Abuse (Per admission) Detoxification and acute care only for alcohol/substance abuse	$200/day, days 1 – 5 $0, days 6+
Substance Abuse Office Visit	$20
Outpatient Substance Abuse Services	$20
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.