

HMO Individual Schedule of Benefits

Provided by:



Health Plans

Underwritten by  Commercial 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

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Health First Silver AV73 HMO 65 1807 SCHEDULE OF BENEFITS AV = 73.63%

| PLAN FEATURES | MEMBER COST-SHARE |
|---|-----------------------------|
| Deductible (Per Individual/Family) Includes medical and pharmacy expenses per calendar year. | \$1,200/\$2,400 |
| Coinsurance | 35% |
| Maximum Out-of-Pocket Expense Limit (Per Individual/Family) Includes medical and pharmacy expenses per calendar year. | \$6,950/\$13,900 |
| COVERED SERVICES ¹ | MEMBER COST-SHARE |
| OUTPATIENT SERVICES AND SUPPLIES Authorization rules may apply. Access your member portal 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 | Deductible then Coinsurance |
| Specialist Office Visit | Deductible then Coinsurance |
| Chiropractic Services 26 visits maximum per calendar year | Deductible then Coinsurance |
| Podiatry Services | Deductible then Coinsurance |
| 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 | Deductible then Coinsurance |
| Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing. | Deductible then Coinsurance |



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|---|-----------------------------|
| 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 | Deductible then Coinsurance |
| Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies | Deductible then Coinsurance |
| Allergy Testing (Per visit) | Deductible then Coinsurance |
| Practitioner-Administered Medications Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections, allergy immunotherapy, and other medications ordered and administered by a provider. | Deductible then Coinsurance |
| Radiation Services | Deductible then Coinsurance |
| Dialysis Services | Deductible then Coinsurance |
| Other Diagnostic and Therapeutic Tests and Services Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits | Deductible then Coinsurance |
| Emergency Room Visit | Deductible then Coinsurance |
| Outpatient Surgery – Facility Services Includes outpatient hospital & Ambulatory Surgery Center. | Deductible then Coinsurance |
| Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital & Ambulatory Surgery Center. | Deductible then Coinsurance |
| Outpatient Observation (Per stay) | Deductible then Coinsurance |
| Durable Medical Equipment, Orthotics, & Prosthetic Devices | Deductible then Coinsurance |



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|---|-----------------------------|
| Home Health Care 60 visits maximum per calendar year | Deductible then Coinsurance |
| Rehabilitative Physical, Speech and Occupational Therapies 35 visits maximum per calendar year for each condition being treated | Deductible then Coinsurance |
| Habilitation Services 35 visits maximum per calendar year for each condition being treated | Deductible then Coinsurance |
| Cardiac & Pulmonary Rehabilitation Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.) | Deductible then Coinsurance |
| Hyperbaric Oxygen Therapy | Deductible then Coinsurance |
| Ambulance Services | Deductible then Coinsurance |
| Outpatient Hospice Services | Deductible then Coinsurance |
| All Other Medically Necessary Outpatient Services | Deductible then Coinsurance |
| INPATIENT MEDICAL SERVICES Authorization rules may apply. Access your member portal to view the Authorization List. | |
| Inpatient Hospital Facility Services (Per admission) Inpatient rehabilitation services limited to 21 days per calendar year. | Deductible then Coinsurance |
| Inpatient Physician and Surgical Services | Deductible then Coinsurance |
| Skilled Nursing Facility Services (Per admission) 60 days maximum per calendar year | Deductible then Coinsurance |
| Inpatient Hospice Services | Deductible then Coinsurance |
| BEHAVIORAL HEALTH SERVICES Authorization rules may apply. Access your member portal to view the Authorization List. | |



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|--|-----------------------------|
| Inpatient Mental Health Care (Per admission) | Deductible then Coinsurance |
| 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. | Deductible then Coinsurance |
| Mental Health Care Office Visit | Deductible then Coinsurance |
| Outpatient Mental Health Services | Deductible then Coinsurance |
| Inpatient Substance Abuse (Per admission) Detoxification and acute care only for alcohol/substance abuse | Deductible then Coinsurance |
| Substance Abuse Office Visit | Deductible then Coinsurance |
| Outpatient Substance Abuse Services | Deductible then Coinsurance |
| PEDIATRIC SERVICES | |
| Pediatric Dental Services Includes one dental check-up visit every six months, basic and major dental care and medically necessary orthodontic services. | \$0 |
| Pediatric Vision Services Includes one routine eye exam and one pair of standard child eyeglasses (frame and lenses) per calendar year from a participating provider. Up to two prescription fills of standard contact lenses are covered, in lieu of eyeglasses, per calendar year from a participating provider. | \$0 |
| ADDITIONAL BENEFITS | |
| Fitness Center Membership | Not covered |
| PRESCRIPTION DRUG BENEFIT Covered prescription drugs are listed in the plan formulary. Authorization rules, step therapy requirements and quantity limits may apply. Please login to your member portal to view the formulary. | |



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| Retail Pharmacy | 30-Day Supply | 90-Day Supply |
|--|----------------------|----------------------|
| Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies. | \$0 | \$0 |
| Tier 1 – Preferred Generic Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 2 – Non-preferred Generic Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 3 – Preferred Brand Name Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 4 – Non-preferred Brand Name Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy. | Deductible then 30% | Not covered |
| Mail Order Pharmacy | 30-Day Supply | 90-Day Supply |
| Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies. | \$0 | \$0 |
| Tier 1 – Preferred Generic Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 2 – Non-preferred Generic Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 3 – Preferred Brand Name Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 4 – Non-preferred Brand Name Prescription Drugs | Deductible then 30% | Deductible then 30% |
| Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy. | Deductible then 30% | Not covered |

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