

## NH HealthFirst Program Benefit Summary

BENEFITS	HealthFirst Plan
<b>Preventive Care Services</b> Immunizations, Lead Screenings, PSA, Routine Physical Exams (including family planning, pre-natal & well child care), Women's Health (including mammography), Routine Hearing, Routine Laboratory and Annual Care Plan for Chronic Illnesses	Covered in full
<b>Other Office Visits</b> Primary Care Copay Specialist Copay	\$20 per visit \$50 per visit
<b>Colonoscopy</b>	\$250 Copay
<b>Deductible (single/family traditional)</b>	<b>Tier 1 Facilities:</b> \$2,500/\$5,000 <b>Tier 2 Facilities:</b> \$4,000/\$8,000
<b>Coinsurance</b>	None
<b>Max out of pocket (single/family traditional)</b>	\$5,000/\$10,000
<b>Lifetime Maximum</b>	No maximum
<b>In/Out Patient Hospital Care</b>	Subject to deductible
<b>Skilled Nursing &amp; Rehab Facilities</b> SNF limited to 100 days/CY; Rehabilitation Facility limited to 60 days/CY	Subject to deductible
<b>Diagnostic Labs and X-Rays</b> Labs X-Rays MRI, CT and PET Scans	Covered in full Subject to deductible Subject to deductible
<b>Outpatient Surgery</b> Doctor's Office Hospital/Surgical Day Care	\$20/\$50 per visit Subject to deductible
<b>Urgent/Emergency Room Care</b> Urgent Care Facility Copay Emergency Room Facility Copay	\$100 per visit \$200 per visit
<b>Ambulance (medically necessary)</b>	Subject to deductible
<b>Short Term Therapy (PT, OT, ST)</b>	\$50 per visit
<b>Chiropractic</b>	Not covered
<b>Mental Health/Substance Abuse Services</b> Office Visits Facility	\$20 per visit Subject to deductible
<b>Durable Medical Equipment</b> Limited to \$3,000/Mbr./CY	Subject to deductible
<b>Prescription Drugs</b> Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy <u>Certain chronic maintenance drugs will be covered at the generic rate.</u> Includes maintenance drugs at a retail and mail order pharmacy. Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days Important Notes: Whenever available, your prescription will be filled generically. If you choose to buy a brand drug, you pay the generic copay, plus the difference in the cost between the brand and generic. If, due to medical necessity, your physician needs to prescribe a brand drug, you pay only the formulary or non-formulary brand copay showing on this summary.	\$10 copay/generic \$35 copay/formulary brand \$50 copay/non-formulary brand No Max  Copayment applies to each fill, up to a 30 day supply for both retail and mail order. Example: a 3-month supply through mail order requires 3 copayments.
<p><b>Members will need to work with a Care Navigator for all elective tests and procedures.</b></p> <p><b>Members will need to establish a relationship with a primary care provider</b></p> <p><b>The benefit plan will additionally cover the following services</b></p> <p>Screening and Brief Intervention for Alcohol and Drug Abuse Body Mass Index Screening After-hours care</p>	

