CoverageFirst®

How it works

What is CoverageFirst?

With CoverageFirst, you can see any provider without a referral – but your costs are usually lower when you use in-network providers. What makes CoverageFirst unique is the **$500-per-covered member** "benefit allowance" that covers many services from in-network providers before you start paying toward your deductible.

Here's how it works:

1. The plan pays the first $500 of eligible expenses from in-network providers. You just pay a copayment.
2. If you use the entire $500, you pay most additional expenses until you meet the annual deductible. The plan has a separate $500 allowance and a separate deductible for each family member; each person's costs also apply to a deductible for the entire family.

Why you might want CoverageFirst

CoverageFirst offers lower premiums and a "safety net" in case of a major illness or injury.

- **Your up-front costs are lower.** CoverageFirst premiums are generally lower than with other plan types.
- **You could have very low out-of-pocket costs.** Many health plan members spend less than $500 a year on medical care.* If you're in that group, the CoverageFirst allowance might cover all of your costs except your copayments.
- **Preventive care coverage.** Even if your $500 is gone, CoverageFirst covers your preventive care office visits. However, you would be responsible for special procedures billed separately, such as lab work.
- **The out-of-pocket maximum provides peace of mind.** If you have a serious illness or injury, your costs for covered services at in-network providers are capped.

Using your allowance

The entire $500 is available on the first day of the plan year. You can use the allowance for:

- Doctor's office visits
- Routine outpatient laboratory tests and X-rays
- Hospital services, including semiprivate room and board, emergency room services, and outpatient surgery
- Other services such as home healthcare, physical therapy, and hospice care

Your allowance isn't depleted when you fill a prescription or receive mental health services. Also, the allowance doesn't cover copayments or any services from out-of-network providers. Check the summary plan description for details about plan benefits, limitations, and exclusions.

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Example one — Lynn (single coverage)

Lynn chooses a CoverageFirst plan with:
- **$500 allowance**
- **$3,000 deductible**
- **100 percent coinsurance** (in-network)

Lynn goes to her primary care physician and finds out she needs some blood work.

• Doctor's office visit (Lynn pays a $25 copayment)	$50
• Outpatient lab (no copayment)	$400
How Lynn uses CoverageFirst	
Total cost of medical services	$450
Lynn's copayments	$25
CoverageFirst pays the remaining costs	**$425**

Summary

Lynn's medical expenses for the calendar year didn't exceed her $500 CoverageFirst allowance. The only medical expenses she paid were copayments totaling $25.

Example two — Greg (family coverage)

Greg chooses a CoverageFirst plan.
Each covered member has:
- **$500 allowance**
- **$2,500 deductible**
- **80 percent coinsurance** (in-network)
- **$3,000 out-of-pocket maximum** (does NOT include the deductible)

Greg is injured in a fall. He goes to the emergency room and spends two days in the hospital. Later, he has a follow-up visit with a specialist.

• Hospital care (Greg pays $500 in copayments)	$10,000
• One specialist visit (Greg pays $50 copayment)	$150
How Greg uses CoverageFirst	
Total cost of medical services	$10,150
Deduct Greg's total copayments	(-$550)
Remaining cost of medical services	$9,650
CoverageFirst pays $500 of remaining cost.	**$9,150**
Greg is now responsible for his deductible	(-$2,500)
Remaining cost of medical services	$6,650
Greg's plan pays 80 percent of remaining cost, leaving Greg to pay 20 percent— **$6,650 x 20% = $1,330**	

Summary

Greg's out-of-pocket maximum is $3,000. He has met $1,330 (his deductible did not apply to the out-of-pocket maximum). Greg must pay $1,670 more in medical costs until he reaches his out-of-pocket maximum. Then his plan will start paying 100 percent of the remaining medical costs for the rest of his plan year.

* These examples may not apply to all lines of business (PPO, POS, HMO)

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