



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [https://hf.org/COC\\_HI\\_2023](https://hf.org/COC_HI_2023). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-443-4735 to request a copy.

| Important Questions   | Answers   | Why this Matters:   |
|---|---|---|
| What is the overall <b>deductible</b> ?                             | \$1,250 person/ \$2,500 family  | Generally, you must pay all of the costs from providers up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b>  |
| Are there services covered before you meet your <b>deductible</b> ? | Preventive services, maternity office visits (1-15 per year)  | This <b>plan</b> covers some items and services even if you haven't yet met the annual <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain preventative services without <b>cost sharing</b> and before you meet your <b>deductible</b> . See a list of covered preventative services at <a href="https://www.healthcare.gov/coverage/preventative-care-benefits/">https://www.healthcare.gov/coverage/preventative-care-benefits/</a> .   |
| Are there other <b>deductibles</b> for specific services?           | Yes, Prescription drugs_\$200 person/\$400 family   | Yes, You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this <b>plan</b> begins to pay for these services.   |
| What is the <b>out-of-pocket limit</b> for this plan?               | \$3,000 person/ \$6,000 family;   | The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> they have to meet their own out-of-pocket limits until the overall family <b>out-of-pocket limit</b> has been met   |
| What is not included in the <b>out-of-pocket limit</b> ?            | Premiums, balance billed charges, non-covered services.   | Even though you pay these expenses, they don't count toward the out-of-pocket limit   |
| Will you pay less if you use a <b>network provider</b> ?            | Yes. See <a href="https://hf.org/MP_directory_2023">https://hf.org/MP_directory_2023</a> or call 1.855.443.4735 for a list of <b>network</b> providers. | This <b>plan</b> uses a provider <b>network</b> . You will pay less if you use a <b>provider</b> in the <b>plan</b> 's <b>network</b> . You will pay the most if you use an out-of- <b>network</b> provider, and you might receive a bill from a <b>provider</b> for the difference between the <b>provider</b> 's charge and what your <b>plan</b> pays (a <b>balance billing</b> ). Be aware your <b>network</b> provider might use an out-of- <b>network</b> provider for some services (such as lab work). Check with your <b>provider</b> before you get services. |
| Do I need a <b>referral</b> to see a <b>specialist</b> ?            | No.   | You can see the <b>specialist</b> you choose without a referral   |



All **copayments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event  | Services You May Need                            | What You Will Pay  |                        | Limitations, Exceptions, & Other Important Information  |
|---|--|--------------------|------------------------|---|
|   |  | Preferred Provider | Non-Preferred Provider |   |
| If you visit a health care <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | \$5 copay/visit    | Not Covered            | None  |
|   | <b>Specialist</b> visit                          | \$40 copay/visit   | Not Covered            | 26 visit maximum - Chiropractor   |
|   | <b>Preventive care / screening</b> /immunization | \$0 copay          | Not covered            | You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for. |
| If you have a test  | <b>Diagnostic test</b> (x-ray, blood work)       | 0% coinsurance     | Not Covered            | See section IV and V of <b>plan</b> document  |
|   | Imaging (CT/PET scans, MRIs)                     | 0% coinsurance     | Not covered            | Requires authorization, without which uncovered expenses might become member's responsibility   |

| Common Medical Event  | Services You May Need   | What You Will Pay  |                        | Limitations, Exceptions, & Other Important Information  |
|---|---|--|------------------------|---|
|   |   | Preferred Provider   | Non-Preferred Provider |   |
| If you need drugs to treat your illness or condition<br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="https://hf.org/MP_formulary_2023">https://hf.org/MP_formulary_2023</a> | Generic drugs<br>(Preferred Generic drugs)<br>(Non-Preferred Generic drugs) | \$2 copay, retail or mail order;<br>\$15 copay, retail or mail order | N/A                    | Copay is for 30 day supply.   |
|   | Preferred brand drugs   | \$30 copay after Rx deductible                                       | N/A                    | Cost share is for retail, mail order. 30 day supply   |
|   | Non-preferred brand drugs   | \$50 copay after Rx deductible                                       | N/A                    | Cost share is for retail, mail order. 30 day supply   |
|   | <b><u>Specialty drugs</u></b>   | 20% coinsurance after Rx deductible                                  | N/A                    | 30 day supply only, preferred pharmacy only, otherwise not covered.                           |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)                              | 0% coinsurance   | Not covered            | Requires authorization, without which uncovered expenses might become member's responsibility |
|   | Physician/surgeon fees  | 0% coinsurance   | Not covered            | Authorization may be required.  |
| If you need immediate medical attention   | <b><u>Emergency room services</u></b>                                       | 0% coinsurance   | 0% coinsurance         | See section IV and V of <b><u>plan</u></b> document   |
|   | <b><u>Emergency medical transportation</u></b>                              | 0% coinsurance   | 0% coinsurance         | See section IV and V of <b><u>plan</u></b> document   |
|   | <b><u>Urgent care</u></b>   | 0% coinsurance   | 0% coinsurance         | See section III.E of <b><u>plan</u></b> document for details.                                 |
| If you have a hospital stay   | Facility fee (e.g., hospital room)  | 0% coinsurance   | Not covered            | Authorization required.   |
|   | Physician/surgeon fee   | 0% coinsurance   | Not covered            | Authorization may be required.  |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |                        | Limitations, Exceptions, & Other Important Information  |
|---|---|---|------------------------|---|
|   |   | Preferred Provider  | Non-Preferred Provider |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 copay office visit; 0% coinsurance other outpatient services | Not covered            | Requires authorization, without which uncovered expenses might become member's responsibility                     |
|   | Inpatient services                        | 0% coinsurance  | Not covered            | Requires authorization, without which uncovered expenses might become member's responsibility                     |
| If you are pregnant   | Office visits                             | \$0 per visit 1-15; ultrasounds 0% coinsurance                    | Not covered            | In <b>network</b> visit 16+ subject to <b>Specialist</b> cost share. Perinatology not included.                   |
|   | Childbirth/delivery professional services | 0% coinsurance  | Not covered            | See Section IV_Obstetrical and Maternity Care   |
|   | Delivery and all inpatient services       | 0% coinsurance  | Not covered            | Requires authorization, without which uncovered expenses might become member's responsibility                     |
| If you need help recovering or have other special health needs            | <b><u>Home health care</u></b>            | 0% coinsurance  | Not covered            | Limit 60 visits per year.   |
|   | <b><u>Rehabilitation services</u></b>     | 0% coinsurance  | Not covered            | 35 visits per year, per condition.  |
|   | <b><u>Habilitation services</u></b>       | 0% coinsurance  | Not covered            | 35 visits per year, per condition.  |
|   | <b><u>Skilled nursing care</u></b>        | 0% coinsurance  | Not covered            | 60 days maximum per year.   |
|   | <b><u>Durable medical equipment</u></b>   | 0% coinsurance  | Not covered            | Preauthorization is required. Failure to get <b>preauthorization</b> could require you to pay 100% of total cost. |
|   | <b><u>Hospice service</u></b>             | 0% coinsurance  | Not covered            | See section IV and V of <b>plan</b> document  |
| If your child needs dental or eye care                                    | Children's eye exam                       | \$0 copay   | Not covered.           | One routine eye exam per year.  |
|   | Children's glasses                        | \$0 copay   | Not covered.           | One pair of eyeglasses (frame and basic lenses) per year. See sections IV and V of <b>plan</b> document.          |
|   | Children's dental check-up                | \$0 copay   | Not covered.           | See sections IV, V, and X of <b>plan</b> document.  |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic services (limited)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1.877.267.2323 x61565 or <http://www.cciio.cms.gov>. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the **Marketplace**, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the **explanation of benefits** you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim appeal** or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

Health First Health Plans Customer Service (weekdays 8am to 6pm)  
Phone Toll-Free: 855.443.4735  
TDD services for the hearing or speech impaired: 800.955.8771  
Fax Number: 1.877.977.2062

Florida's Office of Insurance Regulation (OIR)  
Division of Consumer Services  
Call 1.877.693.5236. (fully-insured plans only)

Health First Health Plans  
P.O. Box 52146 Phoenix, AZ 85072-2146  
<http://www.hf.org>  
[help@hioscar.com](mailto:help@hioscar.com)

**Does this plan provide Minimum Essential Coverage? This plan or policy Does provide minimum essential coverage.**

**Minimum Essential Coverage** generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Not Applicable**

If your plan doesn't meet the **Minimum Value Standard**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855.443.4735.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855.443.4735.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 855.443.4735.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 855.443.4735.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost sharing amounts ( **deductibles** , **copayments** and **coinsurance** ) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible** \$1,250
- **Specialist** copayment \$40
- Hospital (facility) coinsurance 0%
- Other **coinsurance** coinsurance 0%

**This EXAMPLE event includes services like:**

- Specialist** office visits ( prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests** ( ultrasounds and blood work)
- Specialist** visit (anesthesia)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

|                     |  |
|---------------------|--|
| <i>Cost Sharing</i> |  |
|---------------------|--|

|                    |                |
|--------------------|----------------|
| <b>Deductibles</b> | <b>\$1,250</b> |
|--------------------|----------------|

|                   |            |
|-------------------|------------|
| <b>Copayments</b> | <b>\$0</b> |
|-------------------|------------|

|                    |            |
|--------------------|------------|
| <b>Coinsurance</b> | <b>\$0</b> |
|--------------------|------------|

|                           |  |
|---------------------------|--|
| <i>What isn't covered</i> |  |
|---------------------------|--|

|                      |            |
|----------------------|------------|
| Limits or exclusions | <b>\$0</b> |
|----------------------|------------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$1,250</b> |
|-----------------------------------|----------------|

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$1,250
- **Specialist** copayment \$40
- Hospital (facility) coinsurance 0%
- Other **coinsurance** coinsurance 0%

**This EXAMPLE event includes services like:**

- Primary care physician** office visits (including disease education)
- Diagnostic tests** (blood work)
- Prescription drugs**
- Durable medical equipment** (glucose meter)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

|                     |  |
|---------------------|--|
| <i>Cost Sharing</i> |  |
|---------------------|--|

|                      |              |
|----------------------|--------------|
| <b>Deductibles</b> * | <b>\$300</b> |
|----------------------|--------------|

|                   |              |
|-------------------|--------------|
| <b>Copayments</b> | <b>\$800</b> |
|-------------------|--------------|

|                    |            |
|--------------------|------------|
| <b>Coinsurance</b> | <b>\$0</b> |
|--------------------|------------|

|                           |  |
|---------------------------|--|
| <i>What isn't covered</i> |  |
|---------------------------|--|

|                      |            |
|----------------------|------------|
| Limits or exclusions | <b>\$0</b> |
|----------------------|------------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,100</b> |
|-----------------------------------|----------------|

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$1,250
- **Specialist** copayment \$40
- Hospital (facility) coinsurance 0%
- Other **coinsurance** coinsurance 0%

**This EXAMPLE event includes services like:**

- Emergency room care** (including medical supplies)
- Diagnostic test** (x-ray)
- Durable medical equipment** (crutches)
- Rehabilitation services** (physical therapy)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

|                     |  |
|---------------------|--|
| <i>Cost Sharing</i> |  |
|---------------------|--|

|                    |                |
|--------------------|----------------|
| <b>Deductibles</b> | <b>\$1,250</b> |
|--------------------|----------------|

|                   |             |
|-------------------|-------------|
| <b>Copayments</b> | <b>\$80</b> |
|-------------------|-------------|

|                    |            |
|--------------------|------------|
| <b>Coinsurance</b> | <b>\$0</b> |
|--------------------|------------|

|                           |  |
|---------------------------|--|
| <i>What isn't covered</i> |  |
|---------------------------|--|

|                      |            |
|----------------------|------------|
| Limits or exclusions | <b>\$0</b> |
|----------------------|------------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,330</b> |
|-----------------------------------|----------------|

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1.855.443.4735

\*Note: This plan has other **deductibles** for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.