




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. 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 or call 1-855-443-4735 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; \$6,900 policy covers 1 person/ \$13,800 policy of 2+ persons | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u> ? | Preventive services, maternity office visits (1-15 per year) | This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventative services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventative services at https://www.healthcare.gov/coverage/preventative-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No, There are no other specific deductibles. | No, you don't have to meet deductibles for specific services. |
| What is the <u>out-of-pocket limit</u> for this plan? | \$6,900 person/ \$13,800 family; | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> they have to meet their own out-of-pocket limits until the overall family <u>out-of-pocket limit</u> has been met |
| What is not included in the <u>out-of-pocket limit</u> ? | 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 <u>network provider</u> ? | Yes. See https://hf.org/MP_directory_2023 or call 1.855.443.4735 for a list of <u>network</u> providers. | This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of- <u>network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance billing</u>). Be aware your <u>network</u> provider might use an out-of- <u>network</u> provider for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions | Answers | Why this Matters: |
|--|---------|---|
| Do I need a referral to see a specialist ? | No. | You can see the specialist 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 |
|---|--|------------------------------------|---------------------------------------|-----------------------------------|---|
| | | Indian Health Care Provider (IHCP) | Non-IHCP Provider In-Network Provider | Non-IHCP Out-of- Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | 0% coinsurance | Not Covered | Cost sharing waived with IHCP referral |
| | Specialist visit | No charge | 0% coinsurance | Not Covered | Cost sharing waived with IHCP referral 26 visit maximum - Chiropractor. |
| | Preventive care / screening /immunization | No charge | \$0 copay | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 0% coinsurance | Not Covered | Cost sharing waived with IHCP referral See section IV and V of plan document. |
| | Imaging (CT/PET scans, MRIs) | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral 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 |
|---|---|-------------------|--------------------------------------|-------------------------|---|
| | | IHCP | Non-IHCP In-Network | Non-IHCP Out-of-Network | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://hf.org/MP_formulary_2023 | Generic drugs (Preferred Generic drugs) (Non-Preferred Generic drugs) | No charge | 0% coinsurance, retail or mail order | N/A | Cost sharing waived with IHCP referral |
| | Preferred brand drugs | No charge | 0% coinsurance, retail or mail order | N/A | Cost sharing waived with IHCP referral |
| | Non-preferred brand drugs | No charge | 0% coinsurance, retail or mail order | N/A | Cost sharing waived with IHCP referral |
| | Specialty drugs | No charge | 0% coinsurance, retail or mail order | N/A | Cost sharing waived with IHCP referral 30 day supply only, preferred pharmacy only, otherwise not covered. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral Requires authorization |
| | Physician/surgeon fees | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral |
| If you need immediate medical attention | Emergency room care | No charge | 0% coinsurance | 0% coinsurance | Cost sharing waived with IHCP referral See section IV and V of plan document. |
| | Emergency medical transportation | No charge | 0% coinsurance | 0% coinsurance | Cost sharing waived with IHCP referral See section IV and V of plan document. |
| | Urgent care | No charge | 0% coinsurance | 0% coinsurance | Cost sharing waived with IHCP referral See section III.E of plan document for details. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral Requires authorization |
| | Physician/surgeon fee | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|-------------------|---|-------------------------|--|
| | | IHCP | Non-IHCP In-Network | Non-IHCP Out-of-Network | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | 0% coinsurance_office visit and other outpatient services | Not covered | Cost sharing waived with IHCP referral Requires authorization |
| | Inpatient services | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral Requires authorization |
| If you are pregnant | Office visits | No charge | \$0 per visit 1-15; ultrasounds 0% coinsurance | Not covered | Cost sharing waived with IHCP referral In network visit 16+ subject to Specialist cost share. Perinatology not included. |
| | Childbirth/delivery professional services | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral |
| | Childbirth/delivery facility services | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral Requires authorization |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 0% coinsurance | Not covered | Limit 60 visits per year. Cost sharing waived with IHCP referral |
| | <u>Rehabilitation services</u> | No charge | 0% coinsurance | Not covered | 35 visits per year, per condition. Cost sharing waived with IHCP referral |
| | <u>Habilitation services</u> | No charge | 0% coinsurance | Not covered | 35 visits per year, per condition. Cost sharing waived with IHCP referral |
| | <u>Skilled nursing care</u> | No charge | 0% coinsurance | Not covered | 60 days maximum per year. Cost sharing waived with IHCP referral |
| | <u>Durable medical equipment</u> | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP referral Requires authorization |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|-------------------------------|-------------------|----------------------------|-------------------------|--|
| | | IHCP | Non-IHCP In-Network | Non-IHCP Out-of-Network | |
| | <u>Hospice service</u> | No charge | 0% coinsurance | Not covered | Cost sharing waived with IHCP <u>referral</u> See section IV and V of <u>plan</u> document. |
| If your child needs dental or eye care | Children's eye exam | No charge | \$0 copay after deductible | Not covered. | One routine eye exam per year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> |
| | Children's glasses | No charge | \$0 copay after deductible | Not covered. | One pair of eyeglasses (frame and basic lenses) per year. <u>Cost sharing</u> waived with IHCP <u>referral</u> |
| | Children's dental check-up | No charge | \$0 copay after deductible | Not covered. | Cost sharing waived with IHCP <u>referral</u> See section IV and V of <u>plan</u> 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, 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 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

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, kwijijigo 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** \$6,900
- **Specialist** coinsurance 0%
- 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*)

| | |
|---------------------------|----------|
| Total Example Cost | \$12,700 |
|---------------------------|----------|

In this example, Peg would pay:

Cost Sharing

| | |
|--------------------|---------|
| Deductibles | \$6,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|---------|
| The total Peg would pay is | \$6,900 |
|-----------------------------------|---------|

Managing Joe's type 2 Diabetes

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

- The **plan's** overall **deductible** \$6,900
- **Specialist** coinsurance 0%
- 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*)

| | |
|---------------------------|---------|
| Total Example Cost | \$5,600 |
|---------------------------|---------|

In this example, Joe would pay:

Cost Sharing

| | |
|--------------------|---------|
| Deductibles | \$5,400 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|---------|
| The total Joe would pay is | \$5,400 |
|-----------------------------------|---------|

Mia's Simple Fracture

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

- The **plan's** overall **deductible** \$6,900
- **Specialist** coinsurance 0%
- 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*)

| | |
|---------------------------|---------|
| Total Example Cost | \$2,800 |
|---------------------------|---------|

In this example, Mia would pay:

Cost Sharing

| | |
|--------------------|---------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|---------|
| The total Mia would pay is | \$2,800 |
|-----------------------------------|---------|

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: These numbers assume the patient received care from an IHCP **provider** or with IHCP **referral** at a non-IHCP. If you receive care from a non-IHCP **provider** without a **referral** from an IHCP your costs may be higher.

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