HealthFirst
Health Plans
underwritten by Health First Commercial Plans

Gold Savings 1825 LIMITED

Coverage Period: On or after 01/01/2023

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual + Family | Plan Type: HMO

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 **deductible**?	**$0** at Indian Health Care **Provider** (IHCP) or with **referral** at non-IHCP; **$2,900** person/ **$5,800** family	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan** each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**
Are there services covered before you meet your **deductible**?	Preventive services, maternity office visits (1-15 per year)	This **plan** covers some items and services even if you haven't yet met the annual **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain preventative services without **cost sharing** and before you meet your **deductible** See a list of covered preventative services at https://www.healthcare.gov/coverage/preventative-care-benefits/.
Are there other **deductibles** for specific services?	Yes, Prescription drugs_$0 at Indian Health Care **Provider** (IHCP) or with IHCP **referral** at non-IHCP; $200 person/$400 family	Yes, You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the **out-of- pocket limit** for this plan?	$8,650 person/ $17,300 family;	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan** they have to meet their own out-of-pocket limits until the overall family **out-of-pocket limit** has been met
What is not included in the **out–of–pocket limit**?	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 **network provider**?	Yes. See https://hf.org/MP_directory_2023 or call 1.855.443.4735 for a list of **network** providers.	This **plan** uses a provider **network** You will pay less if you use a **provider** in the **plan** s **network** You will pay the most if you use an out-of **network** provider, and you might receive a bill from a **provider** for the difference between the **provider** s charge and what your **plan** pays (a **balance billing** . Be aware your **network** provider might use an out-of **network** provider for some services (such as lab work). Check with your **provider** 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	$25 copay/visit	Not Covered	Cost sharing waived with IHCP **referral**
	Specialist visit	No charge	$50 copay/visit	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 copay diagnostic labs; x-rays 25% coinsurance	Not Covered	Cost sharing waived with IHCP **referral** See section IV and V of **plan** document.
	Imaging (CT/PET scans, MRIs)	No charge	25% 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 **prescription drug coverage** is available at https://hf.org/MP_formulary_2023	Generic drugs (Preferred Generic drugs) (Non-Preferred Generic drugs)	No charge	$3 copay, retail or mail order; $15 copay, retail or mail order	N/A	Cost sharing waived with IHCP referral
	Preferred brand drugs	No charge	$30 copay after Rx deductible	N/A	Cost sharing waived with IHCP referral
	Non-preferred brand drugs	No charge	$55 copay after Rx deductible	N/A	Cost sharing waived with IHCP referral
	Specialty drugs	No charge	25% coinsurance	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	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral** Requires authorization
	Physician/surgeon fees	No charge	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral**
If you need immediate medical attention	Emergency room care	No charge	25% coinsurance	25% coinsurance	Cost sharing waived with IHCP **referral** See section IV and V of **plan** document.
	Emergency medical transportation	No charge	25% coinsurance	25% coinsurance	Cost sharing waived with IHCP **referral** See section IV and V of **plan** document.
	Urgent care	No charge	$30 copay/visit	$30 copay/visit	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	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral** Requires authorization
	Physician/surgeon fee	No charge	25% 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	$50 copay office visit; 25% coinsurance other outpatient services	Not covered	Cost sharing waived with IHCP **referral**. Requires authorization
	Inpatient services	No charge	25% 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 25% 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	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral**
	Childbirth/delivery facility services	No charge	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral**. Requires authorization
If you need help recovering or have other special health needs	**Home health care**	No charge	25% coinsurance	Not covered	Limit 60 visits per year. **Cost sharing** waived with IHCP **referral**
	Rehabilitation services	No charge	25% coinsurance	Not covered	35 visits per year, per condition. **Cost sharing** waived with IHCP **referral**
	Habilitation services	No charge	25% coinsurance	Not covered	35 visits per year, per condition. **Cost sharing** waived with IHCP **referral**
	Skilled nursing care	No charge	25% coinsurance	Not covered	60 days maximum per year. **Cost sharing** waived with IHCP **referral**
	Durable medical equipment	No charge	25% 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	
	Hospice service	No charge	25% coinsurance	Not covered	Cost sharing waived with IHCP **referral** See section IV and V of **plan** document.
If your child needs dental or eye care	Children's eye exam	No charge	$0 copay	Not covered.	One routine eye exam per year.
	Children's glasses	No charge	$0 copay	Not covered.	One pair of eyeglasses (frame and basic lenses) per year. See sections IV and V of **plan** document.
	Children's dental check-up	No charge	$0 copay	Not covered.	Cost sharing waived with IHCP **referral** See section IV and V of **plan** 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	• Hearing aids	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine eye care
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care	• Non-emergency care when traveling outside the U.S.	• 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

Health First Health Plans
P.O. Box 52146 Phoenix, AZ 85072-2146
http://www.hf.org
help@hioscar.com

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

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, kwiijigo 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**	$2,900
Specialist	copayment $50
Hospital (facility)	coinsurance 25%
Other **coinsurance**	coinsurance 25%

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	$2,900
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,700

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The **plan's** overall **deductible**	$2,900
Specialist	copayment $50
Hospital (facility)	coinsurance 25%
Other **coinsurance**	coinsurance 25%

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 *	$200
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,200

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The **plan's** overall **deductible**	$2,900
Specialist	copayment $50
Hospital (facility)	coinsurance 25%
Other **coinsurance**	coinsurance 25%

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	$2,600
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,700

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.