HMO Individual
Schedule of Benefits

Provided by:

Health Plans

Underwritten by Health First Commercial Plans

About this Schedule of Benefits
This Schedule of Benefits outlines the cost-shares (such as deductibles, copayments and coinsurance) that apply to covered services under your plan. It is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. If this Schedule of Benefits conflicts in any way with the Certificate of Coverage (contract), the contract shall prevail. Please review your contract for a description of services, supplies, terms and conditions of coverage.

For multiple outpatient services received on the same date of service, more than one cost-share may apply, unless expressly stated otherwise herein. For example, if you receive an injection in your physician's office, you may be responsible for the cost-share associated with a physician visit and the cost-share associated with practitioner-administered medications under this plan.

How to contact us for help
For assistance regarding information about coverage, questions or complaints, please call Customer Service toll-free at 1.855.443.4735. You may also log onto your secure member portal at myHFHP.org/login.

Health First Health Plans
Underwritten by Health First Commercial Plans

Health First Silver VALUE 80 1815
Limited Cost-Share
SCHEDULE OF BENEFITS

HIGH VALUE NETWORK AV = 67.15%
INDIAN HEALTH CARE PROVIDER AV = 100%

MEMBER COST-SHARE

PLAN FEATURES	High Value Network[1]	In-Network	Indian Health Care Provider
Medical Calendar Year Deductible (Per Individual/Family)	$6,500/ $13,000	$8,000/ $16,000	$0
Pharmacy Calendar Year Deductible (Per Individual/Family)	$200/$400	$200/$400	$0
Coinsurance	20%	30%	$0
Maximum Out-of-Pocket Expense Limit (Per Individual/Family) Includes medical and pharmacy expenses per calendar year.	$8,700/ $17,400	$8,700/ $17,400	$0
COVERED SERVICES[2]	**High Value Network**	**In-Network**	**Indian Health Care Provider**
OUTPATIENT SERVICES AND SUPPLIES Authorization rules may apply. Access your member portal to view the Authorization List.			
Preventive Care Services Services are covered in accordance with Affordable Care Act requirements, including age, risk-factor and frequency guidelines. See HealthCare.gov for the current list of covered preventive services.	$0		
Primary Care Physician Office Visit	$25	$65	$0
Specialist Office Visit	$100	$120	$0
Chiropractic Services 26 visits maximum per calendar year	$100	$120	$0

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COVERED SERVICES[2]	High Value Network	In-Network	Indian Health Care Provider
Podiatry Services	$100	$120	$0
Prenatal/Postnatal Office Visit (not including perinatology) Up to 15 visits per calendar year are covered without cost-sharing in-network. Additional visits are subject to the appropriate physician office visit cost-share.	$0		
Urgent Care Clinic Visit	$80	$80	$0
Diagnostic Lab Services (e.g., blood work) Includes independent clinical labs. Does not include genetic testing.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Genetic Testing Lab Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Radiology Services (Per visit, per type) Includes x-rays, ultrasounds, echocardiograms, fluoroscopies, diagnostic mammography and other standard radiology services.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Maternity Ultrasounds	Deductible then Coinsurance	Deductible then Coinsurance	$0
Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET and Nuclear Studies	Deductible then Coinsurance	Deductible then Coinsurance	$0
Allergy Testing (Per visit)	Deductible then Coinsurance	Deductible then Coinsurance	$0
Practitioner-Administered Medications Medications administered by a health care provider in an office or outpatient setting. Includes chemotherapy, infusions, therapeutic injections, allergy immunotherapy, and other medications ordered and administered by a provider.	Deductible then Coinsurance	Deductible then Coinsurance	$0

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	High Value Network	In-Network	Indian Health Care Provider
Radiation Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Dialysis Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Other Diagnostic and Therapeutic Tests and Services Medically necessary outpatient diagnostic and therapeutic services not classified elsewhere within this Schedule of Benefits	Deductible then Coinsurance	Deductible then Coinsurance	$0
Emergency Room Visit	Deductible then Coinsurance	Deductible then Coinsurance	$0
Outpatient Surgery – Facility Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Outpatient Surgery – Physician/Surgeon Services Includes outpatient hospital & Ambulatory Surgery Center.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Outpatient Observation (Per stay)	Deductible then Coinsurance	Deductible then Coinsurance	$0
Durable Medical Equipment, Orthotics, & Prosthetic Devices	Deductible then Coinsurance	Deductible then Coinsurance	$0
Home Health Care 60 visits maximum per calendar year	Deductible then Coinsurance	Deductible then Coinsurance	$0
Rehabilitative Physical, Speech and Occupational Therapies 35 visits maximum per calendar year for each condition being treated	Deductible then Coinsurance	Deductible then Coinsurance	$0

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Habilitation Services 35 visits maximum per calendar year for each condition being treated	Deductible then Coinsurance	Deductible then Coinsurance	$0
Cardiac & Pulmonary Rehabilitation Coverage is limited to 36 sessions per lifetime, per service. (Additional days may be authorized when medically necessary.)	Deductible then Coinsurance	Deductible then Coinsurance	$0
Hyperbaric Oxygen Therapy	Deductible then Coinsurance	Deductible then Coinsurance	$0
Ambulance Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Outpatient Hospice Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
All Other Medically Necessary Outpatient Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
INPATIENT MEDICAL SERVICES Authorization rules may apply. Access your member portal to view the Authorization List.			
Inpatient Hospital Facility Services (Per admission) Inpatient rehabilitation services limited to 21 days per calendar year.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Inpatient Physician and Surgical Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Skilled Nursing Facility Services (Per admission) 60 days maximum per calendar year	Deductible then Coinsurance	Deductible then Coinsurance	$0

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Inpatient Hospice Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
BEHAVIORAL HEALTH SERVICES Authorization rules may apply. Access your member portal to view the Authorization List.			
Inpatient Mental Health Care (Per admission)	Deductible then Coinsurance	Deductible then Coinsurance	$0
Partial Hospitalization A structured program of active treatment for psychiatric care that is more intense than the care performed in a physician's or therapist's office.	Deductible then Coinsurance	Deductible then Coinsurance	$0
Mental Health Care Office Visit	$100	$120	$0
Outpatient Mental Health Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
Inpatient Substance Abuse (Per admission) Detoxification and acute care only for alcohol/substance abuse	Deductible then Coinsurance	Deductible then Coinsurance	$0
Substance Abuse Office Visit	$100	$120	$0
Outpatient Substance Abuse Services	Deductible then Coinsurance	Deductible then Coinsurance	$0
PEDIATRIC SERVICES			
Pediatric Dental Services Includes one dental check-up visit every six months, basic and major dental care and medically necessary orthodontic services.	$0	$0	$0

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Pediatric Vision Services Includes one routine eye exam and one pair of standard child eyeglasses (frame and lenses) per calendar year from a participating provider. Up to two prescription fills of standard contact lenses are covered, in lieu of eyeglasses, per calendar year from a participating provider.	$0	$0	$0
ADDITIONAL BENEFITS			
Fitness Center Membership	Not covered		

PRESCRIPTION DRUG BENEFIT Covered prescription drugs are listed in the plan formulary. Authorization rules, step therapy requirements and quantity limits may apply. Please access your member portal to view the formulary.		
Retail Pharmacy	**30-Day Supply**	**90-Day Supply**
Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies.	$0	$0
Tier 1 – Preferred Generic Prescription Drugs	$3	$9
Tier 2 – Non-preferred Generic Prescription Drugs	$15	$45
Tier 3 – Preferred Brand Name Prescription Drugs	Deductible then $30	Deductible then $90
Tier 4 – Non-preferred Brand Name Prescription Drugs	Deductible then $55	Deductible then $165

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	MEMBER COST-SHARE	
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then 25%	Not covered
Mail Order Pharmacy	**30-Day Supply**	**90-Day Supply**
Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies.	$0	$0
Tier 1 – Preferred Generic Prescription Drugs	$3	$6
Tier 2 – Non-preferred Generic Prescription Drugs	$15	$30
Tier 3 – Preferred Brand Name Prescription Drugs	Deductible then $30	Deductible then $75
Tier 4 – Non-preferred Brand Name Prescription Drugs	Deductible then $55	Deductible then $137.50
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	Deductible then 25%	Not covered
Indian Health Care Pharmacy	**30-Day Supply**	**90-Day Supply**
Preventive Care Prescription Drugs and Supplies Covered in accordance with Affordable Care Act requirements. A health care professional's prescription is required for all drugs and supplies.	$0	$0
Tier 1 – Preferred Generic Prescription Drugs	$0	$0
Tier 2 – Non-preferred Generic Prescription Drugs	$0	$0
Tier 3 – Preferred Brand Name Prescription Drugs	$0	$0

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Tier 4 – Non-preferred Brand Name Prescription Drugs	$0	$0
Tier 5 – Specialty Drugs Coverage is limited to a 30-day supply from preferred specialty pharmacy.	$0	Not covered

[1] For more information about the High Value Network and a list of participating providers, see the applicable Provider Directory.

[2] Covered services are subject to limitations, exclusions and plan provisions listed in the Certificate of Coverage.