Medicare Advantage

Summary of Benefits

This is a summary of drug and health services covered by Health First Health Plans effective January 1, 2021

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Monthly Plan Premium In addition, you must keep paying your Medicare Part B premium	You pay $97	You pay $33	You pay $0
Deductibles	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility	$3,750 for services you receive from in-network providers $10,000 for services you receive from out-of-network providers	$4,950 for services you receive from in-network providers	$5,500 for services you receive from in-network providers
Inpatient Hospital Coverage (PA) (90 days covered/benefit period†)	✦ You pay $180 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 per day for days 8-90 of a covered inpatient stay during a benefit period ✦ There is a $1,260 maximum out-of-pocket limit per benefit period	✦ You pay $215 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 per day for days 8-90 of a covered inpatient stay during a benefit period ✦ There is a $1,505 maximum out-of-pocket limit per benefit period	✦ You pay $260 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 per day for days 8-90 of a covered inpatient stay during a benefit period ✦ There is a $1,820 maximum out-of-pocket limit per benefit period

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Outpatient Hospital Coverage (PA)	You pay $150 for each Medicare covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility	You pay $300 for each Medicare covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility	You pay $400 for each Medicare covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility
Doctor Visits (Primary Care Providers and Specialists)	✦ You pay $0 for each visit to an in-network primary care physician office ✦ You pay $30 for each visit to a specialty physician office ✦ You pay $0 for each Medicare-covered telehealth primary care visit ✦ You pay $30 for each Medicare-covered telehealth specialist visit	✦ You pay $0 for each visit to a primary care physician office ✦ You pay $32 for each visit to a specialty physician office ✦ You pay $0 for each Medicare-covered telehealth primary care visit ✦ You pay $32 for each Medicare-covered telehealth specialist visit	✦ You pay $0 for each visit to a primary care physician office ✦ You pay $35 for each visit to a specialty physician office ✦ You pay $0 for each Medicare-covered Telehealth Primary Care visit ✦ You pay $35 for each Medicare-covered telehealth specialist visit
Preventive Care	In-network: You pay $0 Out-of-network: You pay 20% of the cost	You pay $0	You pay $0
Emergency Care*	You pay $90 for each Medicare-covered visit	You pay $90 for each Medicare-covered visit	You pay $90 for each Medicare-covered visit
Urgently Needed Services*	✦ You pay $25 for each Medicare-covered urgently needed care visit ✦ You pay $25 for each Medicare-covered telehealth urgent care visit	✦ You pay $35 for each Medicare-covered urgently needed care visit ✦ You pay $35 for each Medicare-covered telehealth urgent care visit	✦ You pay $40 for each Medicare-covered urgently needed care visit ✦ You pay $40 for each Medicare-covered telehealth urgent care visit

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Diagnostic Services/Labs/Imaging (PA)	✦ You pay $0 for Medicare-covered lab services ✦ You pay $0 for each outpatient X-ray, diagnostic procedure & tests ✦ You pay $165 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service	✦ You pay $0 for Medicare-covered lab services ✦ You pay $30 for each outpatient X-ray, diagnostic procedure & tests ✦ You pay $200 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service	✦ You pay $0 for Medicare-covered lab services ✦ You pay $35 for each outpatient X-ray, diagnostic procedure & tests ✦ You pay $200 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service
Hearing Services	✦ You pay $15 for Medicare-covered hearing exams ✦ You pay $15 for one routine hearing test per calendar year ✦ You can be reimbursed up to $350 for the purchase of one hearing aid device per calendar year	✦ You pay $30 for Medicare-covered hearing exams ✦ You can be reimbursed up to $350 for the purchase of one hearing aid device per calendar year	✦ You pay $30 for Medicare-covered hearing exams ✦ You can be reimbursed up to $350 for the purchase of one hearing aid device per calendar year
Dental Services (PA)	✦ You pay $20 for Medicare-covered dental benefits ✦ You can be reimbursed up to $225 for dental services per calendar year	✦ You pay $30 for Medicare-covered dental benefits ✦ You can be reimbursed up to $225 for dental services per calendar year	✦ You pay $35 for Medicare-covered dental benefits ✦ You can be reimbursed up to $225 for dental services per calendar year

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Vision Services	✦ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ✦ You pay $0 for one routine eye exam per calendar year ✦ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ✦ You can be reimbursed up to $150 for contact lenses and eyeglasses per calendar year ✦ You pay $0 for one diabetic retinopathy screening per calendar year when you have a diagnosis of diabetes	✦ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ✦ You pay $30 for one routine eye exam per calendar year ✦ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ✦ You can be reimbursed up to $150 for contact lenses and eyeglasses per calendar year ✦ You pay $0 for one diabetic retinopathy screening per calendar year when you have a diagnosis of diabetes	✦ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ✦ You pay $30 for one routine eye exam per calendar year ✦ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ✦ You can be reimbursed up to $150 for contact lenses and eyeglasses per calendar year ✦ You pay $0 for one diabetic retinopathy screening per calendar year when you have a diagnosis of diabetes
Mental Health Services (PA) (90 days covered / benefit period†)	Inpatient: ✦ You pay $180 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 each day for days 8-90 of a covered inpatient stay during a benefit period There is a $1,260 maximum out-of-pocket limit per benefit period† Outpatient: ✦ You pay $20 for each individual/group therapy visit	Inpatient: ✦ You pay $200 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 each day for days 8-90 of a covered inpatient stay during a benefit period There is a $1,400 maximum out-of-pocket limit per benefit period† Outpatient: ✦ You pay $30 for each individual/group therapy visit	Inpatient: ✦ You pay $200 each day for days 1-7 of a covered inpatient stay during a benefit period ✦ You pay $0 each day for days 8-90 of a covered inpatient stay during a benefit period There is a $1,400 maximum out-of-pocket limit per benefit period† Outpatient: ✦ You pay $35 for each individual/group therapy visit

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Skilled Nursing Facility (PA) (100 days covered / benefit period†)	✦ You pay $0 each day for days 1-20 for a covered stay during a benefit period ✦ You pay $100 each day for days 21-100 for a covered stay during a benefit period ✦ 1- day prior inpatient hospital stay is required	✦ You pay $0 each day for days 1-20 for a covered stay during a benefit period ✦ You pay $180 each day for days 21-100 for a covered stay during a benefit period ✦ 1- day prior inpatient hospital stay is required	✦ You pay $0 each day for days 1-20 for a covered stay during a benefit period ✦ You pay $180 each day for days 21-100 for a covered stay during a benefit period ✦ 1- day prior inpatient hospital stay is required
Physical Therapy and other Rehabilitation Services (PA)	You pay $15 for each Medicare-covered therapy visit	You pay $15 for each Medicare-covered therapy visit	You pay $15 for each Medicare-covered therapy visit
Ambulance (PA)	You pay $230 for a Medicare-covered one-way trip	You pay $240 for a Medicare-covered one-way trip	You pay $250 for a Medicare-covered one-way trip
Transportation	You pay $0 for 20 one-way trips per calendar year	You pay $0 for 20 one-way trips per calendar year	You pay $0 for 20 one-way trips per calendar year
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy drugs, you pay: 20% of the cost Other Part B drugs, you pay: 20% of the cost	For Part B drugs such as chemotherapy drugs, you pay: 20% of the cost Other Part B drugs, you pay: 20% of the cost	For Part B drugs such as chemotherapy drugs, you pay: 20% of the cost Other Part B drugs, you pay: 20% of the cost
Ambulatory Surgery Center (PA)	You pay $150 for each Medicare-covered outpatient admission to an ambulatory surgical center	You pay $300 for each Medicare-covered outpatient admission to an ambulatory surgical center	You pay $400 for each Medicare-covered outpatient admission to an ambulatory surgical center
Foot Care (podiatry services)	You pay $20 for each Medicare-covered visit	You pay $30 for each Medicare-covered visit	You pay $35 for each Medicare-covered visit

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Medical Equipment/Supplies (PA)	✦ Durable Medical Equipment • You pay 20% of the Medicare-allowable amount for each Medicare-covered item ✦ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay $0 for diabetes monitoring supplies, therapeutic shoes, or inserts	✦ Durable Medical Equipment • You pay 20% of the Medicare-allowable amount for each Medicare-covered item ✦ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay 10% of the cost for diabetes monitoring supplies, therapeutic shoes, or inserts	✦ Durable Medical Equipment • You pay 20% of the Medicare-allowable amount for each Medicare-covered item ✦ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay 15% of the cost for diabetic supplies, therapeutic shoes, or inserts
Wellness Programs	These services are offered at no additional cost: ✦ Health First Fitness Program ✦ Healthy Living ✦ Health Coach	These services are offered at no additional cost: ✦ Health First Fitness Program ✦ Healthy Living ✦ Health Coach	These services are offered at no additional cost: ✦ Health First Fitness Program ✦ Healthy Living ✦ Health Coach
Home Health Care (PA)	You pay $0 for Medicare-covered home health care visits	You pay $0 for Medicare-covered home health care visits	You pay $0 for Medicare-covered home health care visits
Annual Routine Physical Exam	You pay $0 for an annual routine physical exam	You pay $0 for an annual routine physical exam	You pay $0 for an annual routine physical exam
In-Home Safety Assessment (PA)	You pay $0 for a Medicare-covered in-home safety assessment, up to one hour per calendar year, post hospitalization	You pay $0 for a Medicare-covered in-home safety assessment, up to one hour per calendar year, post hospitalization	You pay $0 for a Medicare-covered in-home safety assessment, up to one hour per calendar year, post hospitalization
In-Home Support Services (PA)	You pay $0 for Medicare-covered in-home support services, up to four hours per calendar year, post hospitalization	You pay $0 for Medicare-covered in-home support services, up to four hours per calendar year, post hospitalization	You pay $0 for Medicare-covered in-home support services, up to four hours per calendar year, post hospitalization

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Opioid Treatment Program Services (PA)	You pay $20 for each Medicare-covered opioid use disorder treatment service furnished by Opioid Treatment Programs	You pay $30 for each Medicare-covered opioid use disorder treatment service furnished by Opioid Treatment Programs	You pay $35 for each Medicare-covered opioid use disorder treatment service furnished by Opioid Treatment Programs
Supervised Exercise Therapy (SET) (PA)	You pay $10 for each Medicare-covered supervised exercise therapy visit	You pay $20 for each Medicare-covered supervised exercise therapy visit	You pay $20 for each Medicare-covered supervised exercise therapy visit
Chiropractic Services	You pay $20 for each Medicare-covered service	You pay $20 for each Medicare-covered service	You pay $20 for each Medicare-covered service
Point-of-Service**	You pay 20% of the cost for all Medicare-covered services	Not covered	Not covered

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Part D Prescription Drugs – Initial Coverage Stage			
Retail network pharmacy (30-day supply)			
Tier 1 – Preferred Generic Drugs	✦ Tier 1 – $5	✦ Tier 1 – $5	✦ Tier 1 – $5
Tier 2 – Generic Drugs	✦ Tier 2 – $15	✦ Tier 2 – $15	✦ Tier 2 – $15
Tier 3 – Preferred Brand Drugs	✦ Tier 3 – $45	✦ Tier 3 – $45	✦ Tier 3 – $45
Tier 4 – Non-Preferred Drugs	✦ Tier 4 – $90	✦ Tier 4 – $90	✦ Tier 4 – $90
Tier 5 – Specialty Tier Drugs	✦ Tier 5 – 33%	✦ Tier 5 – 33%	✦ Tier 5 – 33%
Tier 6 – Select Care Drugs	✦ Tier 6 – $0	✦ Tier 6 – $0	✦ Tier 6 – $0
Retail network pharmacy (90-day supply)			
Tier 1 – Preferred Generic Drugs	✦ Tier 1 – $15	✦ Tier 1 – $15	✦ Tier 1 – $15
Tier 2 – Generic Drugs	✦ Tier 2 – $45	✦ Tier 2 – $45	✦ Tier 2 – $45
Tier 3 – Preferred Brand Drugs	✦ Tier 3 – $135	✦ Tier 3 – $135	✦ Tier 3 – $135
Tier 4 – Non-Preferred Drugs	✦ Tier 4 – $270	✦ Tier 4 – $270	✦ Tier 4 – $270
Tier 5 – Specialty Tier Drugs	✦ Tier 5 – N/A	✦ Tier 5 – N/A	✦ Tier 5 – N/A
Tier 6 – Select Care Drugs	✦ Tier 6 – $0	✦ Tier 6 – $0	✦ Tier 6 – $0
Mail order (90-day supply)			
Tier 1 – Preferred Generic Drugs	✦ Tier 1 – $9	✦ Tier 1 – $9	✦ Tier 1 – $10
Tier 2 – Generic Drugs	✦ Tier 2 – $30	✦ Tier 2 – $30	✦ Tier 2 – $30
Tier 3 – Preferred Brand Drugs	✦ Tier 3 – $112.50	✦ Tier 3 – $112.50	✦ Tier 3 – $112.50
Tier 4 – Non-Preferred Drugs	✦ Tier 4 – $225	✦ Tier 4 – $225	✦ Tier 4 – $225
Tier 5 – Specialty Tier Drugs	✦ Tier 5 – N/A	✦ Tier 5 – N/A	✦ Tier 5 – N/A
Tier 6 – Select Care Drugs	✦ Tier 6 – $0	✦ Tier 6 – $0	✦ Tier 6 – $0

Preferred retail network pharmacy (30-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	✦ Tier 1 – $3 ✦ Tier 2 – $10 ✦ Tier 3 – $40 ✦ Tier 4 – $80 ✦ Tier 5 – 33% ✦ Tier 6 – $0	✦ Tier 1 – $3 ✦ Tier 2 – $10 ✦ Tier 3 – $40 ✦ Tier 4 – $80 ✦ Tier 5 – 33% ✦ Tier 6 – $0	This plan does not have a preferred retail network
Preferred retail network pharmacy (90-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	✦ Tier 1 – $9 ✦ Tier 2 – $30 ✦ Tier 3 – $120 ✦ Tier 4 – $240 ✦ Tier 5 – N/A ✦ Tier 6 – $0	✦ Tier 1 – $9 ✦ Tier 2 – $30 ✦ Tier 3 – $120 ✦ Tier 4 – $240 ✦ Tier 5 – N/A ✦ Tier 6 – $0	This plan does not have a preferred retail network
Long Term Care Pharmacy (31-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	✦ Tier 1 – $5 ✦ Tier 2 – $15 ✦ Tier 3 – $45 ✦ Tier 4 – $90 ✦ Tier 5 – 33% ✦ Tier 6 – $0	✦ Tier 1 – $5 ✦ Tier 2 – $15 ✦ Tier 3 – $45 ✦ Tier 4 – $90 ✦ Tier 5 – 33% ✦ Tier 6 – $0	✦ Tier 1 – $5 ✦ Tier 2 – $15 ✦ Tier 3 – $45 ✦ Tier 4 – $90 ✦ Tier 5 – 33% ✦ Tier 6 – $0
Coverage Gap Stage	Coverage for Tiers 1, 2, & 6	Coverage for Tier 6 only	No coverage
	After your total yearly drug costs reach $4,130, you will receive limited coverage by the plan on certain drugs. You will pay no more than 25% on brand name drugs and 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $6,550.		
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $6,550, you pay $3.70 copay for generic and $9.20 copay for all other drugs, or 5% coinsurance *(whichever is greater)*.		

Prescription Drug Cost-Sharing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

A Medicare Advantage plan is not a Medigap Policy.

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal. This information is not a complete description of benefits. Call 1-800-716-7737 (TTY/TDD relay: 1-800-955-8771) for more information.

(PA) Covered services that need approval in advance.

†A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

*Worldwide urgent/emergency care coverage: Health First Medicare Advantage Plans cover emergency services and unforeseen urgently needed medical care outside the United States, including when you are on a cruise ship. If you receive covered care from a provider outside the United States that does not participate with Medicare, you may be asked to pay up front for the services and be reimbursed from the plan later. We will pay up to 115% of the Medicare-allowed amount in our service area (Medicare's limiting charge for non-participating providers), less any applicable cost-share. Please note that Medicare-allowed amounts can be much less than the provider charges you, and you will be responsible for paying the difference.

**Point-of-Service means you may use providers outside of the plan's network for an additional cost. Please refer to the Evidence of Coverage for out-of-pocket and annual maximum coverage amounts. Facilities may charge different amounts, so your final cost may vary depending on which facility you choose.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy- five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day / 7 days a week;
- Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778
- State Medicaid Office at 1-866-762-2237. TTY users should call 1-800-955-8771; or
- My Advocate™ (Third Party Administrator for Health First Health Plans) at 1-866-743-5282 between 9 a.m. – 6 p.m., Monday through Friday. TTY users should call 1-855-368-9643

For further assistance: You may call Customer Service toll-free at 1-800-716-7737 (TTY/TDD relay: 1-800-955-8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 am to 8 pm. You may also visit

our website at myHFHP.org, visit our office Monday through Friday, 8 a.m. to 5 p.m. or write to us at 6450 US Highway 1, Rockledge, FL 32955.

To join Health First Health Plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: Brevard and Indian River.

Health First Health Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" online at myHFHP.org or by calling Customer Service toll-free at 1-800-716-7737 (TTY/TDD relay: 1-800-955-8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 am to 8 pm.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

An **HMO** is a type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

An **HMO-POS** is a Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing Plan Members to seek care outside of the traditional HMO network under certain situations or for certain treatment.

This document is available in other formats, such as large print or audio.

You can see our plan's provider/pharmacy directory at our website at myHFHP.org/order
You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at myHFHP.org/order

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Health First Health Plans

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1.800.716.7737 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 to March 31, we're available seven days a week from 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit myHFHP.org or call 1.800.716.7737 (TTY/TDD relay: 1.800.955.8771) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ When selecting an HMO product, remember that except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ When selection an HMO-POS product, our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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