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	Monthly Plan Premium 	\$148.50; may vary depending on your income and the amount of financial assistance you receive	\$0
	Primary Care Provider 	\$203 deductible and 20% coinsurance	\$0 copay
	Specialist 	\$203 deductible and 20% coinsurance	\$45 copay
VISION	Routine Annual Exam 	No coverage	\$0 copay
	Eyewear 	No coverage	\$250 allowance every 2 years for 1 pair of eyeglasses or contact lenses
HEARING	Routine Annual Exam 	No coverage	\$0 copay
	Hearing Aids 	No coverage	\$0–\$1,475 copay per hearing aid every year ^{††}
DENTAL	Cleanings, Exams, X-rays 	No coverage	\$0 copay*
	Other Dental Services 	No coverage	\$0 copay for extractions, dentures, crowns, and more*
	Generic Drugs (one-month supply) 	No coverage	Tier 1 (Preferred Generic): \$0 copay Tier 2 (Generic [‡]): \$10 copay**
	Rx Deductible 	No coverage	\$250
	Over-the-Counter (OTC) Items 	No coverage	Get \$35/quarter (\$140 per year) ²
	Routine Transportation 	No coverage	Get 12 one-way trips per year ²
	Inpatient Hospital Care 	\$1,484 deductible for each benefit period Days 1–60: \$0 copay per day; Days 61–90: \$371 copay per day; Days 91–150: \$742 copay per day	Days 1–5: \$399/day Days 6+: \$0/day Unlimited additional days [†]
	Emergency Care 	\$203 deductible and 20% coinsurance; worldwide care is generally not available, but there are exceptions	\$90 copay
	Urgent Care Coverage 	\$203 deductible and 20% coinsurance	\$65 copay
	Retail Health Clinic 	No coverage	\$15 copay
	Outpatient Diagnostic Procedures, Tests, and Lab Services 	\$203 deductible and 20% coinsurance for doctor services; a copay may be required for other services; 100% coverage of lab services	\$0 copay for lab services; \$50 copay for diagnostic procedures and tests
	Annual Wellness Visit and Health Screenings 	\$0 copay	\$0 copay
	Supplemental Acupuncture 	No coverage	\$0 copay; 12 visits per year
	Teladoc 	No coverage	\$0 copay
	SilverSneakers® 	No coverage	\$0 copay
	Long-Term Care Services and Supports 	No coverage	No coverage
	Worldwide Emergency Coverage 	No coverage	No maximum

¹2021 Original Medicare benefits.

²Healthfirst Signature Choice Extras optional benefit. Upon plan enrollment, only one optional benefit can be chosen. For the OTC allowance Choice Extras optional benefit, OTC items are subject to the plan's list of eligible items and the plan's participating network of retail and online providers.

*\$100 deductible applies to comprehensive dental services. The \$100 deductible is waived for Healthfirst Signature enrollees who choose this as their Healthfirst Signature Choice Extras optional benefit. Maximum plan benefit is \$2,500 per year for combined preventive and comprehensive services.

**After \$250 deductible has been met.

†Based on medical necessity.

††\$0–\$1,475 copays based on technology level.

‡Some generic drugs are in higher tiers with higher copays.

If you have questions or comments, please call Healthfirst Member Services at 1-877-237-1303 (TTY 1-888-542-3821), 7 days a week, 8am–8pm. Coverage is provided by Healthfirst Health Plan, Inc. Plans contain exclusions and limitations. Healthfirst Health Plan, Inc. offers HMO plans that contract with the Federal Government. Enrollment in Healthfirst Medicare Plan depends on contract renewal. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved. Telemedicine (Teladoc) isn't a replacement for your primary care provider (PCP). Your PCP should always be your first choice for care (both in-person and virtual visits). Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.