






















BENEFITS		Original Medicare <sup>1</sup>	Coordinated Benefits Plan (HMO)
	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	\$10 copay
	Specialist 	\$203 deductible and 20% coinsurance	\$35 copay
VISION	Routine Annual Exam 	No coverage	\$0 copay
	Eyewear	No coverage	\$0–\$45 copay or \$100 allowance for 1 pair of eyeglasses or contact lenses every 2 years
HEARING	Routine Annual Exam 	No coverage	\$0 copay
	Hearing Aids	No coverage	\$500 allowance for both ears combined every year
DENTAL	Cleanings, Exams, X-rays 	No coverage	\$5 copay
	Other Dental Services	No coverage	Low copays for extractions, dentures, crowns, and more
	Generic Drugs (one-month supply) 	No coverage	No coverage
	Rx Deductible 	No coverage	No coverage
	Over-the-Counter (OTC) Items 	No coverage	No coverage
	Routine Transportation 	No coverage	Get 8 one-way trips per year
	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: \$403/day Days 6+: \$0/day Unlimited additional days <sup>2</sup>
	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	\$35 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	No coverage
	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	\$200,000

<sup>1</sup>2021 Original Medicare benefits.

<sup>2</sup>Based on medical necessity.

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.