2027 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Health First Classic H1099-001 (HMO-POS)
Health First Value H1099-006 (HMO)
Health First Rewards H1099-014 (HMO)

January 1, 2027 – December 31, 2027

Y0089_EL1105286_M, Accepted 08/25/2026

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, https://www.hf.org/healthplans.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO), and Health First Rewards H1099-014 (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO),** and **Health First Rewards H1099-014 (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- 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 https://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.

Sections in this booklet

- Things to Know About **Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO),** and **Health First Rewards H1099-014 (HMO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-800-716-7737 (TTY: 1-800-955-8771).

Things to Know About Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO), and Health First Rewards H1099-014 (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday and Saturday from 8:00 a.m. – noon.
- If you are a member of this plan, call us at 1-800-716-7737, TTY: 1-800-955-8771.
- If you are not a member of this plan, call us at 1-800-716-7737, TTY: 1-800-955-8771.
- Our website: https://www.hf.org/healthplans.

Who can join?

To join **Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO), and Health First Rewards H1099-014 (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service areas for **Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO), and Health First Rewards H1099-014 (HMO)** include the following counties in Florida: Brevard and Indian River.

Which doctors, hospitals, and pharmacies can I use?

Health First Classic H1099-001 (HMO-POS), Health First Value H1099-006 (HMO), and **Health First Rewards H1099-014 (HMO)** have 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 **if you do not have out of network coverage**. An HMO-POS plan offers a more flexible network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (https://www.hf.org/healthplans).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, https://www.hf.org/healthplans.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Health First Health Plans, Inc.

2 SECTION II - SUMMARY OF BENEFITS

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Premiums and Benefits	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Monthly Plan Premium	$90 per month. In addition, you must keep paying your Medicare Part B premiums.	$25 per month. In addition, you must keep paying your Medicare Part B premiums.	You do not pay a separate monthly plan premium for Health First Rewards H1099-014 (HMO). You must continue to pay your Medicare Part B premium.
Part B Premium Reduction Amount	This plan does not have a Part B premium reduction amount.	This plan does not have a Part B premium reduction amount.	This plan does not have a Part B premium reduction amount.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $600 for Tiers 3, 4, and 5.	Medical Deductible: Not Applicable. Prescription Drug Deductible: $600 for Tiers 3, 4, and 5.	Medical Deductible: Not Applicable. Prescription Drug Deductible: $700 for Tiers 3, 4, and 5.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: • $3,600 for services you receive from in-network providers. • $10,000 for services you receive from out-	Your yearly limit(s) in this plan: • $3,900 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered	Your yearly limit(s) in this plan: • $4,100 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered

	of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	hospital and medical services, and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	hospital and medical services, and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Inpatient Hospital Coverage (PA)	**In-Network:** Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day. **Out-of-Network:** 20% of the total cost per stay.	**In-Network:** Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day.	**In-Network:** Days 1-7: $200 copay per day for each admission. Days 8-90: $0 copay per day.
Outpatient Hospital Coverage (PA)	**In-Network:** Outpatient hospital observation: $150 copay. Outpatient hospital surgery: $0 - $150 copay. **Out-of-Network:** Outpatient hospital observation: 20% of the total cost. Outpatient hospital surgery: 20% of the total cost.	**In-Network:** Outpatient hospital observation: $175 copay. Outpatient hospital surgery: $0 - $175 copay.	**In-Network:** Outpatient hospital observation: $200 copay. Outpatient hospital surgery: $0 - $200 copay.
Ambulatory Surgical Center (ASC) Services (PA)	**In-Network:** Ambulatory surgical center: $0 - $150 copay. **Out-of-Network:** Ambulatory surgical center: 20% of the total cost.	**In-Network:** Ambulatory surgical center: $0 - $175 copay.	**In-Network:** Ambulatory surgical center: $0 - $200 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Doctor Visits (Primary Care Providers and Specialists) (PA)	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $25 copay. **Out-of-Network:** Primary care physician visit: 20% of the total cost. Specialist visit: 20% of the total cost.	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $25 copay.	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $25 copay.
Preventive Care (PA)	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 20% of the total cost for all preventive services covered under Original Medicare at zero cost sharing.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Emergency Care	**In-Network:** Emergency care: $150 copay per visit. Worldwide emergency coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.	**In-Network:** Emergency care: $150 copay per visit. Worldwide emergency coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.	**In-Network:** Emergency care: $150 copay per visit. Worldwide emergency coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.
Urgently Needed Services	**In-Network:** Urgently needed services: $20 copay per visit. Worldwide urgent coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.	**In-Network:** Urgently needed services: $20 copay per visit. Worldwide urgent coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.	**In-Network:** Urgently needed services: $20 copay per visit. Worldwide urgent coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Diagnostic Services/Labs/Imaging (PA)	**In-Network:** Diagnostic tests and procedures: $10 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $150 copay. X-rays: $10 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. **Out-of-Network:** Diagnostic tests and procedures: 20% of the total cost. Lab services: 20% of the total cost. Diagnostic radiology services (such as MRI, CAT Scan): 20% of the total cost. X-rays: 20% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost.	**In-Network:** Diagnostic tests and procedures: $20 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $150 copay. X-rays: $20 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost.	**In-Network:** Diagnostic tests and procedures: $30 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $150 copay. X-rays: $30 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Hearing Services	**In-Network:** Medicare-covered hearing exam (diagnostic hearing exam): $15 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing aids (up to 2 hearing aids every year): $0 - $1,395 copay. Fitting/Evaluation (up to 1 visit(s) every year): $0 copay. **Out-of-Network:** Medicare-covered hearing exam (diagnostic hearing exam): 20% of the total cost.	**In-Network:** Medicare-covered hearing exam (diagnostic hearing exam): $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing aids (up to 2 hearing aids every year): $0 - $1,395 copay. Fitting/Evaluation (up to 1 visit(s) every year): $0 copay.	**In-Network:** Medicare-covered hearing exam (diagnostic hearing exam): $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing aids (up to 2 hearing aids every year): $0 - $1,395 copay. Fitting/Evaluation (up to 1 visit(s) every year): $0 copay.
Dental Services (PA)	**In-Network:** Medicare-covered dental benefits: $20 copay. You will receive a preloaded debit card with $1,000 per calendar year for any supplemental diagnostic, preventive, or comprehensive dental service. Services paid for using the debit card are not subject to dental	**In-Network:** Medicare-covered dental benefits: $30 copay. You will receive a preloaded debit card with $750 per calendar year for any supplemental diagnostic, preventive, or comprehensive dental service. Services paid for using the debit card are not subject to dental	**In-Network:** Medicare-covered dental benefits: $35 copay. Dental maximum benefit coverage amount: $1,250 allowance per year. Diagnostic and preventive dental services:

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
	service frequency limits; however, coverage is limited to the annual amount available. **<u>Out-of-Network:</u>** Medicare-covered dental benefits: 20% of the total cost.	service frequency limits; however, coverage is limited to the annual amount available.	• Oral exam (up to 2 every year). • Cleaning (up to 2 every year). • Fluoride treatment (up to 1 every year). • Dental X-rays (up to 1 every 12 - 36 months, depending on the procedure). Comprehensive dental services: • Restorative services (up to 1 every 2 years per surface per tooth for fillings and 5 years for crowns). • Periodontics (up to 1 every 6 - 36 months). • Oral and maxillofacial surgery services (up to 1 every 60 months for oroantral fistula closure; extractions are unlimited).

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
			• Adjunctive general services (up to 1 every 0 - 12 months). You will also receive a preloaded debit card with $400 per calendar year for any supplemental diagnostic, preventive, or comprehensive dental service. Services paid for using the debit card are not subject to dental service frequency limits; however, coverage is limited to the annual amount available.
Vision Services (PA)	**In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $15 copay. Glaucoma screening: $0 copay. Routine vision exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay.	**In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $15 copay. Glaucoma screening: $0 copay. Routine vision exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay.	**In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $15 copay. Glaucoma screening: $0 copay. Routine vision exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
	Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Our plan pays up to $300 every year for supplemental eyewear. **Out-of-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): 20% of the total cost. Glaucoma screening: 20% of the total cost. Eyeglasses or contact lenses after cataract surgery: 20% of the total cost.	Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Our plan pays up to $300 every year for supplemental eyewear.	Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Our plan pays up to $300 every year for supplemental eyewear.
Mental Health Services (PA)	**In-Network:** Outpatient group therapy visit: $15 copay. Individual therapy visit: $15 copay. Inpatient mental health care: Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day.	**In-Network:** Outpatient group therapy visit: $15 copay. Individual therapy visit: $15 copay. Inpatient mental health care: Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day.	**In-Network:** Outpatient group therapy visit: $15 copay. Individual therapy visit: $15 copay. Inpatient mental health care: Days 1-7: $200 copay per day for each admission. Days 8-90: $0 copay per day.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
	Out-of-Network: Outpatient group therapy visit: 20% of the total cost. Individual therapy visit: 20% of the total cost. Inpatient mental health care: 20% of the total cost per stay.		
Skilled Nursing Facility (SNF) (PA)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $100 copay per day. **Out-of-Network:** 20% of the total cost per stay.	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $180 copay per day.	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $180 copay per day.
Physical Therapy and other Rehabilitation Services	**In-Network:** Occupational therapy visit: $5 copay. Physical therapy, speech therapy, and language therapy visit: $5 copay. **Out-of-Network:** Occupational therapy visit: 20% of the total cost. Physical therapy, speech therapy, and language	**In-Network:** Occupational therapy visit: $10 copay. Physical therapy, speech therapy, and language therapy visit: $10 copay.	**In-Network:** Occupational therapy visit: $15 copay. Physical therapy, speech therapy, and language therapy visit: $15 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
	therapy visit: 20% of the total cost.		
Ambulance (PA)	**In-Network:** Ground ambulance: $230 copay. Air ambulance: 20% of the total cost. Worldwide emergency transportation: $230 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year. **Out-of-Network:** Ground ambulance: 20% of the total cost. Air ambulance: 20% of the total cost.	**In-Network:** Ground ambulance: $240 copay. Air ambulance: 20% of the total cost. Worldwide emergency transportation: $240 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.	**In-Network:** Ground ambulance: $250 copay. Air ambulance: 20% of the total cost. Worldwide emergency transportation: $250 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.
Transportation	**In-Network:** $0 copay. 20 one-way trips every year to any health-related location.	**In-Network:** $0 copay. 20 one-way trips every year to any health-related location.	**In-Network:** $0 copay. 20 one-way trips every year to any health-related location.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Medicare Part B Drugs (PA)	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Other Part B drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump.	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Other Part B drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump.	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Other Part B drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump.

PRESCRIPTION DRUG BENEFITS			
Benefits/Services	**Health First Classic H1099-001 (HMO-POS)**	**Health First Value H1099-006 (HMO)**	**Health First Rewards H1099-014 (HMO)**
Deductible	Prescription Drug Deductible: $600 for Tiers 3, 4, and 5.	Prescription Drug Deductible: $600 for Tiers 3, 4, and 5.	Prescription Drug Deductible: $700 for Tiers 3, 4, and 5.
Initial Coverage You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move on to the Catastrophic Coverage Stage.			
	Standard Retail Cost-Sharing	**Standard Retail Cost-Sharing**	**Standard Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a one-month supply of Formulary Insulins.	$0 copay No more than $0 for a one-month supply of Formulary Insulins.	$0 copay No more than $0 for a one-month supply of Formulary Insulins.
Tier 2 (Generic)	$10 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$47 copay No more than $35 for a one-month supply of Formulary Insulins.	$47 copay No more than $35 for a one-month supply of Formulary Insulins.	$47 copay No more than $35 for a one-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	26% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	26% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	25% coinsurance No more than $35 for a one-month supply of Formulary Insulins.
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a two-month supply of Formulary Insulins.	$0 copay No more than $0 for a two-month supply of Formulary Insulins.	$0 copay No more than $0 for a two-month supply of Formulary Insulins.

Tier 2 (Generic)	$20 copay	$20 copay	$20 copay
Tier 3 (Preferred Brand)	$94 copay No more than $70 for a two-month supply of Formulary Insulins.	$94 copay No more than $70 for a two-month supply of Formulary Insulins.	$94 copay No more than $70 for a two-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.
Tier 2 (Generic)	$30 copay	$30 copay	$30 copay
Tier 3 (Preferred Brand)	$141 copay No more than $105 for a three-month supply of Formulary Insulins.	$141 copay No more than $105 for a three-month supply of Formulary Insulins.	$141 copay No more than $105 for a three-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
	Preferred Retail Cost-Sharing	**Preferred Retail Cost-Sharing**	**Preferred Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a one-month supply of Formulary Insulins.	$0 copay No more than $0 for a one-month supply of Formulary Insulins.	$0 copay No more than $0 for a one-month supply of Formulary Insulins.
Tier 2 (Generic)	$5 copay	$5 copay	$5 copay

Tier 3 (Preferred Brand)	$42 copay No more than $35 for a one-month supply of Formulary Insulins.	$42 copay No more than $35 for a one-month supply of Formulary Insulins.	$42 copay No more than $35 for a one-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	30% coinsurance No more than $35 for a one-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	26% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	26% coinsurance No more than $35 for a one-month supply of Formulary Insulins.	25% coinsurance No more than $35 for a one-month supply of Formulary Insulins.
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a two-month supply of Formulary Insulins.	$0 copay No more than $0 for a two-month supply of Formulary Insulins.	$0 copay No more than $0 for a two-month supply of Formulary Insulins.
Tier 2 (Generic)	$10 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$84 copay No more than $70 for a two-month supply of Formulary Insulins.	$84 copay No more than $70 for a two-month supply of Formulary Insulins.	$84 copay No more than $70 for a two-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.	30% coinsurance No more than $70 for a two-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.
Tier 2 (Generic)	$15 copay	$15 copay	$15 copay

Tier 3 (Preferred Brand)	$126 copay No more than $105 for a three-month supply of Formulary Insulins.	$126 copay No more than $105 for a three-month supply of Formulary Insulins.	$126 copay No more than $105 for a three-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
	Standard Mail Order Cost-Sharing	**Standard Mail Order Cost-Sharing**	**Standard Mail Order Cost-Sharing**
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.	$0 copay No more than $0 for a three-month supply of Formulary Insulins.
Tier 2 (Generic)	$0 copay	$0 copay	$0 copay
Tier 3 (Preferred Brand)	$117.50 copay No more than $105 for a three-month supply of Formulary Insulins.	$117.50 copay No more than $105 for a three-month supply of Formulary Insulins.	$117.50 copay No more than $105 for a three-month supply of Formulary Insulins.
Tier 4 (Non-Preferred Drug)	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.	30% coinsurance No more than $105 for a three-month supply of Formulary Insulins.
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Your cost-sharing may be different if you use a long-term care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (https://www.hf.org/healthplans) for complete information about your costs for covered drugs.			
Catastrophic Amount After your yearly out-of-pocket drug costs reach $2,400, you pay nothing.			

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-716-7737 (TTY: 1-800-955-8771).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-716-7737 (TTY: 1-800-955-8771).

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. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Health First Health Plans, Inc. members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by 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 1-800-955-8771).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit https://www.hf.org/healthplans or call 1-800-716-7737 (TTY 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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, 2028.
- ☐ 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 selecting 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.

THANK YOU

Connect with us

Contact Information: 1-800-716-7737, TTY: 1-800-955-8771

Organization Name: Health First Health Plans, Inc.

Organization website: https://www.hf.org/healthplans

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services.

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-716-7737 (TTY: 1-800-955-8771) or speak to your provider.

Spanish (Español): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-716-7737 (TTY: 1-800-955-8771) o hable con su proveedor.

Haitian Creole (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-716-7737 (TTY: 1-800-955-8771) oswa pale avèk founisè w la.

Vietnamese (Việt): LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-716-7737 (TTY: 1-800-955-8771) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Brazilian Portuguese (Português do Brasil): ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-716-7737 (TTY: 1-800-955-8771) ou fale com seu provedor.

Traditional Chinese (中文): 注意：如果您說 中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-716-7737 (TTY: 1-800-955-8771) 或與您的提供者討論。」

French (Français): Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-716-7737 (TTY: 1-800-955-8771) ou parlez à votre fournisseur.

Tagalog (Tagalog): PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-716-7737 (TTY: 1-800-955-8771) o makipag-usap sa iyong provider.

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Russian (РУССКИЙ): ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-716-7737 (TTY: 1-800-955-8771) или обратитесь к своему поставщику услуг.

Arabic (العربية): إذا كنت تتحدث اللغة العربية ، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر مجانًا وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بتنسيقات سهلة الوصول. اتصل على الرقم 1-800-716-7737 (1-800-955-8771 TTY: 1) أو تواصل مع مقدم الخدمة.

Italian (Italiano): ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1-800-716-7737 (TTY: 1-800-955-8771) o parla con il tuo fornitore.

German (Deutsch): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-716-7737 (TTY: 1-800-955-8771) an oder sprechen Sie mit Ihrem Provider.

Korean (한국어): 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-716-7737 (TTY: 1-800-955-8771) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Polish (POLSKI): UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-716-7737 (TTY: 1-800-955-8771) lub porozmawiaj ze swoim dostawcą.

Gujarati (ગુજરાતી): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-716-7737 (TTY: 1-800-955-8771) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Thai (ไทย): หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-716-7737 (TTY: 1-800-955-8771) หรือปรึกษาผู้ให้บริการของคุณ