

## **Annual Notice of Change for 2026**

You're enrolled as a member of Elderplan Select (HMO-POS I-SNP/IE-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Elderplan Select (HMO-POS I-SNP/IE-SNP).
- To change to a **different plan**, visit [www.Medicare.gov](http://www.Medicare.gov) or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [www.elderplan.org](http://www.elderplan.org) or call Member Services at 1-800-353-3765 (TTY users call 711) to get a copy by mail.
- To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare drug plan) at any time.

### **More Resources**

- This material is available for free in Spanish.
- Call Member Services at 1-800-353-3765 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

- This information is available in different formats, including braille and other alternate formats. Please call Member Services at the number listed above if you need plan information in another format or language.

### **About Elderplan Select (HMO-POS I-SNP/IE-SNP)**

- Elderplan is an HMO plan with a Medicare contract. Enrollment in Elderplan depends on contract renewal. Anyone entitled to Medicare Parts A and B may apply. Enrolled members must continue to pay their Medicare Part B premium.
- When this material says “we,” “us,” or “our,” it means Elderplan, Inc. When it says “plan” or “our plan,” it means Elderplan Select (HMO-POS I-SNP/IE-SNP).
- Elderplan has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) through 2026 based on a review of Elderplan’s Model of Care.
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in Elderplan Select (HMO-POS I-SNP/IE-SNP).** Starting January 1, 2026, you’ll get your medical and drug coverage through Elderplan Select (HMO-POS I-SNP/IE-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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**Elderplan Select (HMO-POS I-SNP/IE-SNP)**

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**Summary of Important Costs for 2026**

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Monthly plan premium*</b> * Your premium can be higher than this amount. Go to Section 1.1 for details.	You do not pay a Part D Premium.	You do not pay a Part D Premium. There is no change for 2026.
<b>Part B Deductible</b>	There is no Part B Deductible.	There is no Part B Deductible. There is no change for 2026.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Maximum out-of-pocket amount</b>                      This is the <u>most</u> you'll pay out of pocket for your in-network and out-of-network combined covered Part A and Part B services.                      (Go to Section 1.2 for details.)</p>	<p><b>In-Network and Out-of-Network Combined</b>                      \$7,500</p>	<p><b>In-Network and Out-of-Network Combined</b>                      \$7,500                      There is no change for 2026.</p>
<p><b>Primary care office visits</b></p>	<p><b>In-Network and Out-of-Network</b>                      You pay \$0 Copayment per visit</p>	<p><b>In-Network and Out-of-Network</b>                      You pay \$0 Copayment per visit                      There is no change for 2026.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Specialist office visits</b>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay \$45 Copayment per visit</p> <p>Referrals may be required.</p> <p>You pay \$0 copayment per office visit for:</p> <ul style="list-style-type: none"> <li>• Endocrinologist. Referrals may be required.</li> <li>• Urologist. Referrals may be required.</li> </ul>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay \$45 Copayment per visit</p> <p>Referrals may be required.</p> <p>You pay \$0 copayment per office visit for:</p> <ul style="list-style-type: none"> <li>• Endocrinologist. Referrals may be required.</li> <li>• Urologist. Referrals may be required.</li> </ul> <p>There is no change for 2026.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Inpatient hospital stays</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay per admission:  Days 1-6: \$320 copayment each day  Days 7 and beyond: \$0 copayment each day</p> <p>Authorization Required</p>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay per admission:  Days 1-6: \$320 copayment each day  Days 7 and beyond: \$0 copayment each day</p> <p>Authorization Required</p> <p>There is no change for 2026.</p>
<p><b>Part D drug coverage deductible</b></p> <p>(Go to Section 1.6 for details.)</p>	<p>Deductible: The Part D Deductible is \$0</p>	<p>Deductible: The Part D Deductible is \$0</p> <p>There is no change for 2026.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Part D drug coverage</b>                      (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p>	<p>During the Initial Coverage Stage:  <b>Standard Retail Cost Sharing (in-network)*Ω</b>                      Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:  <b>Tier 1:</b>  <b>Preferred Generic Drugs –</b>                      You Pay \$0 copayment.  <b>Tier 2: Generic Drugs –</b> You Pay \$2 copayment.</p>	<p>During the Initial Coverage Stage:  <b>Standard Retail Cost Sharing (in-network)*Ω</b>                      Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:  <b>Tier 1:</b>  <b>Preferred Generic Drugs –</b>                      You Pay \$0 copayment.  <b>Tier 2: Generic Drugs –</b> You Pay \$2 copayment.</p>

	2025 (this year)	2026 (next year)
<b>Part D drug coverage (continued)</b>	<p><b>Tier 3: Preferred Brand Drugs</b> – You Pay \$25 copayment.</p> <p><b>Tier 4: Non-Preferred Drugs</b> – You Pay \$100 copayment</p> <p><b>Tier 5: Specialty Drugs</b> – You Pay 25% coinsurance.</p> <p>Your cost for an extended supply (up to 90 days)†Ω filled at a network pharmacy with standard cost sharing during the Initial Coverage Stage:</p>	<p><b>Tier 3: Preferred Brand Drugs</b> – You Pay \$25 copayment.</p> <p><b>Tier 4: Non-Preferred Drugs</b> – You Pay \$100 copayment</p> <p><b>Tier 5: Specialty Drugs</b> – You Pay 25% coinsurance.</p> <p>Your cost for an extended supply (up to 90 days)†Ω filled at a network pharmacy with standard cost sharing during the Initial Coverage Stage:</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Part D drug coverage (continued)</b>	<p><b>Tier 1: Preferred Generic Drugs –</b>  Retail – You Pay \$0 copayment.  Mail Order – You Pay \$0 copayment.</p> <p><b>Tier 2: Generic Drugs –</b> Retail – You Pay \$6 copayment.  Mail Order – You Pay \$4 copayment.</p> <p><b>Tier 3: Preferred Brand Drugs –</b>  Retail – You Pay \$75 copayment.  Mail Order – You Pay \$50 copayment.</p>	<p><b>Tier 1: Preferred Generic Drugs –</b>  Retail – You Pay \$0 copayment.  Mail Order – You Pay \$0 copayment.</p> <p><b>Tier 2: Generic Drugs –</b> Retail – You Pay \$6 copayment.  Mail Order – You Pay \$4 copayment.</p> <p><b>Tier 3: Preferred Brand Drugs –</b>  Retail – You Pay \$75 copayment.  Mail Order – You Pay \$50 copayment.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Part D drug coverage (continued)</b>	<p><b>Tier 4: Non-Preferred Drugs –</b>  Retail – You Pay \$300 copayment.  Mail Order – You Pay \$200 copayment.</p> <p><b>Tier 5: Specialty Drugs –</b>  Retail – You Pay 25% coinsurance.  Mail Order – You Pay 25% coinsurance.</p> <p>*60-Days supply is also available for Standard Retail.</p>	<p><b>Tier 4: Non-Preferred Drugs –</b>  Retail – You Pay \$300 copayment.  Mail Order – You Pay \$200 copayment.</p> <p><b>Tier 5: Specialty Drugs –</b>  Retail – You Pay 25% coinsurance.  Mail Order – You Pay 25% coinsurance.</p> <p>*60-Days supply is also available for Standard Retail.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Part D drug coverage (continued)</b>	<p>†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω-You will not pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible.</p>	<p>†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω-You will not pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Part D drug coverage (continued)</b>	<p>If you get “Extra Help” paying for your drugs, you may be eligible for reduced cost-sharing. Please refer to your “Low Income Subsidy (LIS) Rider.”</p> <p>Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.</p>	<p>If you get “Extra Help” paying for your drugs, you may be eligible for reduced cost-sharing. Please refer to your “Low Income Subsidy (LIS) Rider.”</p> <p>Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.</p> <p>There is no change for 2026.</p>

**SECTION 1 Changes to Benefits & Costs for  
Next Year**

**Section 1.1 Changes to the Monthly Plan Premium**

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Monthly plan premium</b> (You must also continue to pay your Medicare Part B premium.)	You do not pay a Part D Premium.	You do not pay a Part D Premium. There is no change for 2026.
<b>Part B premium reduction</b> This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	\$2.50	\$2.50 There is no change for 2026.

### **Factors that could change your Part D Premium Amount**

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

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### **Section 1.2 Changes to Your Maximum Out-of-Pocket Amount**

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Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Maximum out-of-pocket amount</b></p> <p>Your costs for covered medical services (such as copayments) <b>count</b> toward your maximum out-of-pocket amount In-Network and Out-of-Network Combined.</p> <p>Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	<p><b>In-Network and Out-of-Network Combined</b></p> <p>\$7,500</p> <p>Once you have paid \$7,500 out of pocket for In-Network and Out-of-Network combined covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p>	<p><b>In-Network and Out-of-Network Combined</b></p> <p>\$7,500</p> <p>Once you have paid \$7,500 out of pocket for In-Network and Out-of-Network combined covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p> <p>There is no change for 2026.</p>

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### **Section 1.3 Changes to the Provider Network**

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Our network of providers has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.elderplan.org](http://www.elderplan.org) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.elderplan.org](http://www.elderplan.org).
- Call Member Services at 1-800-353-3765 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-353-3765 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

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### **Section 1.4 Changes to the Pharmacy Network**

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Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.elderplan.org](http://www.elderplan.org) to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.elderplan.org](http://www.elderplan.org).
- Call Member Services at 1-800-353-3765 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-353-3765 (TTY users call 711) for help.

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**Section 1.5 Changes to Benefits & Costs for  
Medical Services**

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	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Cardiac Rehabilitation Services</b>	<b>In-Network</b> You pay \$35 copayment for Medicare covered Cardiac Rehabilitation Services.  Authorization is required.	<b>In-Network</b> You pay \$30 copayment for Medicare covered Cardiac Rehabilitation Services.  Authorization is required.
	You pay \$45 copayment for Medicare covered Intensive Cardiac Rehabilitation Services.  Authorization is required.	You pay \$40 copayment for Medicare covered Intensive Cardiac Rehabilitation Services.  Authorization is required.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Emergency care</b>	<p>You pay \$110 for each Medicare covered emergency room visit.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, there is no cost-sharing.</p>	<p>You pay \$115 for each Medicare covered emergency room visit.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, there is no cost-sharing.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Emergency care (continued)</b>	<p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost sharing you would pay at a network hospital.</p>	<p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost sharing you would pay at a network hospital.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Hearing services</b>	<p><b>In-Network</b></p> <p>You pay no coinsurance, copayment, or deductible for Medicare covered diagnostic hearing exams.</p> <p>Authorization is <u>NOT</u> required by a Provider or Specialist.</p> <p>You pay no coinsurance, copayment, or deductible for Non-Medicare Covered Routine Hearing Exams, Fitting/Evaluation for Hearing Aid, and Hearing Aids (all types) once every three years.</p>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay no coinsurance, copayment, or deductible for Medicare covered diagnostic hearing exams.</p> <p>Authorization is <u>NOT</u> required by a Provider or Specialist.</p> <p><b>In-Network</b></p> <p>You pay no coinsurance, copayment, or deductible for Non-Medicare Covered Routine Hearing Exams, Fitting/Evaluation for Hearing Aid, and Hearing Aids (all types).</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Hearing services (continued)</b>	Hearing Aids (all types) are covered up to \$2,000 for both ears combined every 3 years.	You will receive a \$1,000 annual allowance to use in 2026 for Routine Hearing Exams, Fitting/ Evaluation for Hearing Aid and Hearing Aids (all types).  Any unused benefit dollars will expire at the end of the calendar year or if you disenroll from the plan.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Medicare Part B Covered Preventive and Screening Services</b></p>	<p>There is no coinsurance, copayment, or deductible for the following services.</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screenings &amp; counseling</li> <li>• Blood-based biomarker test</li> <li>• Bone mass measurements</li> <li>• Cardiovascular disease screenings</li> <li>• Cardiovascular disease (behavioral therapy)</li> </ul>	<p>There is no coinsurance, copayment, or deductible for the following services.</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screenings</li> <li>• Alcohol misuse screenings &amp; counseling</li> <li>• Bone mass measurements</li> <li>• Cardiovascular disease screenings</li> <li>• Cardiovascular disease (behavioral therapy)</li> </ul>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Medicare Part B Covered Preventive and Screening Services (continued)</b></p>	<ul style="list-style-type: none"> <li>● Cervical and vaginal cancer screening</li> <li>● Colorectal cancer screenings                             <ul style="list-style-type: none"> <li>○ Multi-target stool DNA tests</li> <li>○ Screening barium enemas</li> <li>○ Screening colonoscopies</li> <li>○ Fecal occult blood tests</li> <li>○ Screening flexible sigmoidoscopies</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Cervical &amp; vaginal cancer screenings</li> <li>● Colorectal cancer screenings                             <ul style="list-style-type: none"> <li>○ Blood-based biomarker tests</li> <li>○ Colonoscopies</li> <li>○ Computed tomography (CT) colonography</li> <li>○ Fecal occult blood tests</li> <li>○ Flexible sigmoidoscopies</li> <li>○ Multi-target stool DNA tests</li> </ul> </li> </ul>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<p><b>Medicare Part B Covered Preventive and Screening Services (continued)</b></p>	<ul style="list-style-type: none"> <li>• Counseling to prevent tobacco use &amp; tobacco-caused disease</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma screenings</li> <li>• Hepatitis B shots</li> <li>• Hepatitis B Virus (HBV) infection screenings</li> <li>• Hepatitis C Screening Tests</li> <li>• HIV screenings</li> </ul>	<ul style="list-style-type: none"> <li>• Counseling to prevent tobacco use &amp; tobacco-caused disease</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma screenings</li> <li>• Hepatitis B shots</li> <li>• Hepatitis B virus (HBV) infection screenings</li> <li>• Hepatitis C virus screenings</li> <li>• HIV screenings</li> </ul>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Medicare Part B Covered Preventive and Screening Services (continued)</b>	<ul style="list-style-type: none"> <li>• Lung cancer screenings</li> <li>• Mammograms (screening)</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Obesity screenings and counseling</li> <li>• One-time “Welcome to Medicare” preventive visit</li> <li>• Prostate cancer screenings (PSA)</li> </ul>	<ul style="list-style-type: none"> <li>• Lung cancer screenings</li> <li>• Mammograms (screening)</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Obesity behavioral therapy</li> <li>• One-time “Welcome to Medicare” preventive visit</li> <li>• Pre-exposure prophylaxis (PrEP) for HIV prevention</li> <li>• Prostate cancer screenings</li> </ul>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Medicare Part B Covered Preventive and Screening Services (continued)</b>	<ul style="list-style-type: none"> <li>• Sexually transmitted infections screenings &amp; counseling</li> <li>• Shots: <ul style="list-style-type: none"> <li>○ COVID-19 vaccines</li> <li>○ Flu shots</li> <li>○ Hepatitis B shots</li> <li>○ Pneumococcal shots</li> </ul> </li> <li>• Yearly “Wellness” Visit</li> </ul>	<ul style="list-style-type: none"> <li>• Sexually transmitted infections screenings &amp; counseling</li> <li>• Shots: <ul style="list-style-type: none"> <li>○ COVID-19 vaccines</li> <li>○ Flu shots</li> <li>○ Hepatitis B shots</li> <li>○ Pneumococcal shots</li> </ul> </li> <li>• Yearly “Wellness” visit</li> </ul>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Medicare Part B Prescription Drugs</b>	<p><b>In-Network</b></p> <p>You pay 20% coinsurance for Medicare Part B Prescription Drugs.</p> <p>You pay Up to \$35 for Medicare Part B Insulin Drugs.</p> <p>Medicare Part B Chemotherapy/Radiation Drugs may require authorization.</p> <p>Authorization may be required for certain drugs.</p>	<p><b>In-Network</b></p> <p>You pay 20% coinsurance for Medicare Part B Prescription Drugs.</p> <p>You pay Up to \$35 for Medicare Part B Insulin Drugs.</p> <p>Medicare Part B Chemotherapy/Radiation Drugs authorization is <u>NOT</u> required.</p> <p>Authorization may be required for certain drugs.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Outpatient Rehabilitation Services</b>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay \$35 copayment for Occupational Therapy per visit.</p> <p>You pay \$40 copayment for Physical Therapy or Speech/Language Pathology Services per visit.</p> <p>Authorization is NOT required.</p>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay \$35 copayment for Occupational Therapy per visit.</p> <p>You pay \$40 copayment for Physical Therapy or Speech/Language Pathology Services per visit.</p> <p>Authorization is required.</p>
<b>Urgently Needed Services</b>	<p><b>In-Network</b></p> <p>You pay \$45 copayment for each Urgently Needed Services visit.</p>	<p><b>In-Network</b></p> <p>You pay \$40 copayment for each Urgently Needed Services visit.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Vision care</b>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay no coinsurance or copayment for Medicare covered preventative and diagnostic eye exams (including eye exams if you have diabetes, glaucoma tests, and macular degeneration tests and treatment).</p> <p><b>In-Network</b></p> <p>You pay \$0 Copayment for one pair of Medicare covered eyeglasses or contact lenses after cataract surgery.</p>	<p><b>In-Network and Out-of-Network</b></p> <p>You pay no coinsurance or copayment for Medicare covered preventative and diagnostic eye exams (including eye exams if you have diabetes, glaucoma tests, and macular degeneration tests and treatment).</p> <p>You pay \$0 Copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Vision care (continued)</b>	Eyewear provided after cataract surgery are not subject to the maximum amount (\$500 maximum every two calendar years).	Eyewear provided after cataract surgery are not subject to the (\$150 maximum annually).

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Vision care - Other Covered Services</b>	<p><b>In-Network</b> You pay \$0 Copayment for one routine eye exam every year. You pay \$0 Copayment for eyewear (\$500 maximum every 2 calendar years) including contact lenses or eyeglasses (lenses and frames).</p>	<p><b>In-Network</b> You pay no coinsurance or copayment for Vision Care – Other Covered services. You will receive a \$150 allowance to use in 2026 for Routine Eye Exams and Eyewear. Any unused benefit dollars will expire at the end of the calendar year or if you disenroll from the plan.</p>

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**Section 1.6 Changes to Part D Drug Coverage**

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**Changes to Our Drug List**

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-353-3765 (TTY users call 711) for more information.

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## Section 1.7 Changes to Prescription Drug Benefits & Costs

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### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn't get this material with this packet, call Member Services at 1-800-353-3765 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,100.

- ***Stage 3: Catastrophic Coverage***

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

**Drug Costs in Stage 1: Yearly Deductible**

The table shows your cost per prescription during this stage.

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Yearly Deductible</b>	Because we have no deductible, this payment stage doesn't apply to you.	Because we have no deductible, this payment stage doesn't apply to you.

**Drug Costs in Stage 2: Initial Coverage**

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Initial Coverage</b>	<p><b>Standard Retail Cost Sharing (in-network)*<math>\Omega</math></b></p> <p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:</p> <p><b>Tier 1: Preferred Generic Drugs – You Pay \$0 copayment.</b></p> <p><b>Tier 2: Generic Drugs – You Pay \$2 copayment.</b></p>	<p><b>Standard Retail Cost Sharing (in-network)*<math>\Omega</math></b></p> <p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:</p> <p><b>Tier 1: Preferred Generic Drugs – You Pay \$0 copayment.</b></p> <p><b>Tier 2: Generic Drugs – You Pay \$2 copayment.</b></p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Initial Coverage (continued)</b>	<p><b>Tier 3:</b> <b>Preferred Brand Drugs</b> – You Pay \$25 copayment.</p> <p><b>Tier 4: Non-Preferred Drugs</b> – You Pay \$100 copayment</p> <p><b>Tier 5: Specialty Drugs</b> – You Pay 25% coinsurance.</p> <hr/> <p>Your cost for an extended supply (up to 90 days)†Ω filled at a network pharmacy with standard cost sharing during the Initial Coverage Stage:</p>	<p><b>Tier 3:</b> <b>Preferred Brand Drugs</b> – You Pay \$25 copayment.</p> <p><b>Tier 4: Non-Preferred Drugs</b> – You Pay \$100 copayment</p> <p><b>Tier 5: Specialty Drugs</b> – You Pay 25% coinsurance.</p> <hr/> <p>Your cost for an extended supply (up to 90 days)†Ω filled at a network pharmacy with standard cost sharing during the Initial Coverage Stage:</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Initial Coverage (continued)</b>	<p><b>Tier 1: Preferred Generic Drugs –</b> Retail – You Pay \$0 copayment. Mail Order – You Pay \$0 copayment.</p> <p><b>Tier 2: Generic Drugs –</b> Retail – You Pay \$6 copayment. Mail Order – You Pay \$4 copayment.</p> <p><b>Tier 3: Preferred Brand Drugs –</b> Retail – You Pay \$75 copayment. Mail Order – You Pay \$50 copayment.</p>	<p><b>Tier 1: Preferred Generic Drugs –</b> Retail – You Pay \$0 copayment. Mail Order – You Pay \$0 copayment.</p> <p><b>Tier 2: Generic Drugs –</b> Retail – You Pay \$6 copayment. Mail Order – You Pay \$4 copayment.</p> <p><b>Tier 3: Preferred Brand Drugs –</b> Retail – You Pay \$75 copayment. Mail Order – You Pay \$50 copayment.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Initial Coverage (continued)</b>	<p><b>Tier 4: Non-Preferred Drugs –</b> Retail – You Pay \$300 copayment. Mail Order – You Pay \$200 copayment.</p> <p><b>Tier 5: Specialty Drugs –</b> Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance.</p> <p>*60-Days supply is also available for Standard Retail.</p>	<p><b>Tier 4: Non-Preferred Drugs –</b> Retail – You Pay \$300 copayment. Mail Order – You Pay \$200 copayment.</p> <p><b>Tier 5: Specialty Drugs –</b> Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance.</p> <p>*60-Days supply is also available for Standard Retail.</p>

	2025 (this year)	2026 (next year)
<b>Initial Coverage (continued)</b>	<p>†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω-You will not pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible.</p>	<p>†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.</p> <p>Ω-You will not pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing for Part B and D drugs, even if you have not paid your deductible.</p>

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Initial Coverage (continued)</b>	If you get “Extra Help” paying for your drugs, you may be eligible for reduced cost-sharing. Please refer to your “Low Income Subsidy (LIS) Rider.”	If you get “Extra Help” paying for your drugs, you may be eligible for reduced cost-sharing. Please refer to your “Low Income Subsidy (LIS) Rider.”

### **Changes to the Catastrophic Coverage Stage**

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

**SECTION 2 Administrative Changes**

	<b>2025 (this year)</b>	<b>2026 (next year)</b>
<b>Medicare Prescription Payment Plan</b>	<p>The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.</p>	<p>If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-866-490-2102 (TTY users call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</p>

### **SECTION 3 How to Change Plans**

**To stay in Elderplan Select (HMO-POS I-SNP/IE-SNP), you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Elderplan Select (HMO-POS I-SNP/IE-SNP).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Elderplan Select (HMO-POS I-SNP/IE-SNP).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Elderplan Select (HMO-POS I-SNP/IE-SNP).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-800-353-3765 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4).

- **To learn more about Original Medicare and the different types of Medicare plans**, visit [www.Medicare.gov](http://www.Medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Elderplan, Inc. offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

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### **Section 3.1 Deadlines for Changing Plans**

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People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

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### **Section 3.2 Are there other times of the year to make a change?**

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In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

#### **SECTION 4 Get Help Paying for Prescription Drugs**

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.

- **Help from your state’s pharmaceutical assistance program (SPAP).** New York has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the New York AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you’re currently enrolled, how to continue getting help, call 1-800-542-2437. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-353-3765 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 5 Questions?

### Get Help from Elderplan Select (HMO-POS I-SNP/IE-SNP)

- **Call Member Services at 1-800-353-3765. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Elderplan Select (HMO-POS I-SNP/IE-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [www.elderplan.org](http://www.elderplan.org) or call Member Services at 1-800-353-3765 (TTY users call 711) to ask us to mail you a copy.

- **Visit [www.elderplan.org](http://www.elderplan.org)**

Our website has the most up-to-date information about our provider network (*Provider Directory and Pharmacy Directory*) and our *List of Covered Drugs* (formulary/ Drug List).

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## **Get Free Counseling about Medicare**

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The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called The Office for the Aging Health Insurance Information, Counseling and Assistance Program (HIICAP).

Call HIICAP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call HIICAP at (212) 602-4180 inside the boroughs or 1-800-701-0501 outside the boroughs. Learn more about HIICAP by visiting [aging.ny.gov/programs/medicare-and-health-insurance](https://aging.ny.gov/programs/medicare-and-health-insurance)

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## **Get Help from Medicare**

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- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with [www.Medicare.gov](https://www.Medicare.gov)**

You can chat live at [www.Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- Visit [www.Medicare.gov](http://www.Medicare.gov)

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- Read *Medicare & You 2026*

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [www.Medicare.gov](http://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**Elderplan, Inc.**  
**Notice of Nondiscrimination – Discrimination is Against the Law**

Elderplan/HomeFirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that Elderplan/HomeFirst has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Elderplan, Inc.  
ATTN Civil Rights Coordinator  
55 Water Street, 46<sup>th</sup> Floor  
New York NY 10041

Phone: 1-877-326-9978, TTY 711  
Fax: 1-718-759-3643

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, Civil Rights Coordinator, is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW, Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**English:** Elderplan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a non-English language or require interpretation assistance, language assistance services and appropriate auxiliary aids are available to you free of charge. If you need these services or have questions about our plan, call 1-800-353-3765 (TTY: 711).

**Spanish:** Elderplan, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si usted habla en un idioma que no es inglés o requiere asistencia de interpretación, tiene a su disposición servicios de asistencia lingüística y las ayudas auxiliares adecuadas de forma gratuita. Si necesita estos servicios o tiene preguntas sobre nuestro plan, llame al 1-800-353-3765 (TTY: 711).

**Chinese:** Elderplan, Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障情況或性別而歧視任何人。請注意：如果您說英語以外的語言或需要口譯協助，我們將免費為您提供語言協助服務和適當的輔助工具。如果您需要這些服務或對我們的計劃有疑問，請致電 1-800-353-3765 (TTY: 711)。

**Albanian:** Elderplan, Inc. u përmbahet ligjeve të zbatueshme federale për të drejtat civile, ndaj nuk ju diskriminon në bazë të racës, ngjyrës, origjinës kombëtare, moshës, aftësive të kufizuara ose seksit. VËMENDJE: Nëse flisni një gjuhë tjetër që nuk është anglisht ose nëse keni nevojë për shërbime përkthimi, për ju ofrohen falas shërbime të ndihmës gjuhësore dhe mjete ndihmëse të përshtatshme. Nëse keni nevojë për këto shërbime ose nëse keni pyetje rreth planit tonë, telefononi 1-800-353-3765 (TTY: 711).

#### Arabic

لقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تميّز على أساس العرق أو اللون أو الأصل. Elderplan Inc. تمتثل للقومي أو العمر أو الإعاقة أو الجنس. تنبيه: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في الترجمة الفورية، فإن خدمات المساعدة اللغوية والمساعدات المعينة المناسبة متاحة لك مجاناً. إذا كنت بحاجة إلى هذه الخدمات أو كانت لديك أسئلة حول خطتنا، فاتصل بالرقم 1-800-353-3765 (TTY: 711).

**Bengali:** Elderplan, Inc. প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, বর্ণ, জাতীগত উৎপত্তি, বয়স, অক্ষমতা বা লিঙ্গের ভিত্তিতে বৈষম্য করে না। লক্ষ্য করুন: যদি আপনি ইংরেজি ছাড়া অন্য কোনো ভাষায় কথা বলেন বা দোভাষী সহায়তার প্রয়োজন হয়, আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং প্রয়োজনীয় সহায়ক উপকরণ উপলব্ধ আছে। আপনার যদি এই পরিষেবাগুলির প্রয়োজন হয় বা আমাদের পরিকল্পনা সম্পর্কে প্রশ্ন থাকে তবে 1-800-353-3765 (TTY: 711) নম্বরে ফোন করুন।

**French:** Elderplan, Inc. se conforme aux lois fédérales applicables en matière de droits civils et ne fait aucune discrimination fondée sur la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe. ATTENTION : Si vous parlez une langue autre que l'anglais ou si vous avez besoin d'une assistance d'interprétation, des services d'assistance linguistique et des aides auxiliaires appropriées sont à votre disposition gratuitement. Si vous avez besoin de ces services ou si vous avez des questions sur notre régime d'assurance maladie, appelez le 1-800-353-3765 (TTY : 711).

**German:** Elderplan, Inc. hält alle geltenden Bundesbürgerrechtsgesetze ein und diskriminiert nicht aufgrund von Ethnie, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht. HINWEIS: Wenn Sie eine andere als die englische Sprache sprechen oder einen Dolmetscher benötigen, stehen Ihnen Sprachassistentendienste und geeignete Hilfsmittel kostenlos zur Verfügung. Falls Sie solche Dienste benötigen oder Fragen zu unserem Plan haben, rufen Sie uns bitte unter der Nummer +1-800-353-3765 (TTY: 711) an.

**Greek:** Η Elderplan, Inc. συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους περί πολιτικών δικαιωμάτων και δεν κάνει διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο. ΠΡΟΣΟΧΗ: Αν μιλάτε άλλη γλώσσα εκτός από τα αγγλικά ή χρειάζεστε τη βοήθεια διερμηνείας, παρέχονται δωρεάν υπηρεσίες γλωσσικής υποστήριξης και κατάλληλα βοηθητικά μέσα. Εάν χρειάζεστε αυτές τις υπηρεσίες ή έχετε ερωτήσεις σχετικά με το πρόγραμμά μας, καλέστε στο 1-800-353-3765 (TTY: 711).

**Haitian Creole:** Elderplan, Inc. konfòme l avèk lwa Federal sou dwa sivil ki aplikab yo epi li pa fè diskriminasyon sou baz ras, koulè, orijin nasyon, laj, andikap oswa sèks. ATANSYON: Si ou pale yon lang ki pa Angle oswa ou bezwen asistans entèprèt, sèvis asistans lang ak èd oksilyè ki apwopriye yo disponib pou ou gratis. Si ou bezwen sèvis sa yo oswa ou gen kesyon sou plan nou an, rele 1-800-353-3765 (TTY: 711).

**Hindi:** Elderplan, Inc. लागू संघीय नागरिक अधिकार कानूनों का अनुपालन करता है और नस्ल, रंग, राष्ट्रीय मूल, उम्र, विकलांगता या लिंग के आधार पर भेदभाव नहीं करता है। ध्यान दें: यदि आप एक गैर-अंग्रेज़ी भाषा बोलते हैं या आपको भाषांतरण सहायता की आवश्यकता है, तो भाषा सहायता सेवाएँ और उपयुक्त सहायक उपकरण आपके लिए निःशुल्क उपलब्ध हैं। यदि आपको इन सेवाओं की आवश्यकता है या हमारी योजना के बारे में प्रश्न हैं, तो 1-800-353-3765 (TTY: 711) पर कॉल करें।

**Italian:** Elderplan, Inc. è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso. ATTENZIONE: Se parla una lingua diversa dall'inglese o ha bisogno dell'assistenza di un interprete, può usufruire gratuitamente di servizi di assistenza linguistica e di appositi supporti ausiliari. Se necessita di questi servizi o ha domande sul nostro piano, chiami il numero 1-800-353-3765 (TTY: 711).

**Japanese:** Elderplan, Inc. は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、性別に基づいて差別しません。注意：英語以外の言語を話す場合や通訳のサポートが必要な場合は、言語サポートサービスと適切な補助器具を無料でご利用いただけます。これらのサービスが必要な場合、または当社のプランについてご質問がある場合は、1-800-353-3765 (TTY: 711) までお電話ください。

**Korean:** Elderplan, Inc.는 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 근거로 차별하지 않습니다. 주의: 영어 이외의 언어를 구사하거나 통역 지원이 필요한 경우 언어 지원 서비스 및 적절한 보조 장치를 무료로 이용할 수 있습니다. 이러한 서비스가 필요하거나 플랜에 대해 질문이 있는 경우 1-800-353-3765 (TTY: 711) 로 전화하십시오.

**Polish:** Elderplan, Inc. przestrzega obowiązujących federalnych przepisów dotyczących praw obywatelskich i nie dyskryminuje ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność ani płeć. UWAGA: Jeśli mówisz w języku innym niż angielski lub potrzebujesz pomocy tłumacza, możesz bezpłatnie skorzystać z usług pomocy językowej i odpowiednich narzędzi pomocniczych. Jeśli potrzebujesz tych usług lub masz pytania dotyczące naszego planu, zadzwoń pod numer 1-800-353-3765 (TTY: 711).

**Portuguese:** A Elderplan, Inc. cumpre as leis federais de direitos civis aplicáveis e não discrimina com base em raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala uma língua diferente do inglês ou necessita de assistência de interpretação, estão disponíveis gratuitamente serviços de assistência linguística e recursos auxiliares apropriados. Se precisar destes serviços ou tiver dúvidas sobre o nosso plano, ligue para 1-800-353-3765 (TTY: 711).

**Punjabi:** Elderplan, Inc. ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਅਧਿਕਾਰ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦਾ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਆਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦਾ ਹੈ। ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਕੋਈ ਅੰਗਰੇਜ਼ੀ ਤੋਂ ਬਿਨਾਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ ਜਾਂ ਵਿਆਖਿਆ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੁੰਦੀ ਹੈ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਜੇ ਤੁਹਾਨੂੰ ਇਹਨਾਂ ਸੇਵਾਵਾਂ ਦੀ ਲੋੜ ਹੈ ਜਾਂ ਸਾਡੀ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ 1-800-353-3765 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**Russian:** Компания Elderplan, Inc. соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. ВНИМАНИЕ: Если вы не говорите на английском языке или вам нужна помощь переводчика, вам будут бесплатно предоставлены услуги языковой помощи и соответствующие вспомогательные средства. Если вам нужны такие услуги или у вас есть вопросы о нашем плане, позвоните по номеру 1-800-353-3765 (TTY: 711).

**Tagalog:** Sumusunod ang Elderplan, Inc. sa naaangkop na mga batas sa Pederal na mga karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. ATENSYON: Kung nagsasalita ka ng wikang hindi Ingles o nangangailangan ng tulong sa interpretasyon, ang mga serbisyo ng tulong sa wika at naaangkop na mga pantulong na tulong ay magagamit mo nang walang bayad. Kung kailangan mo ang mga serbisyong ito o may mga tanong tungkol sa aming plano, tawagan ang 1-800-353-3765 (TTY: 711).

## Urdu

Elderplan/HomeFirst قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور نسل، رنگ، قومیت، عمر، معذوری، یا جنس کی بنیاد پر امتیازی سلوک نہیں کرتا۔ توجہ: اگر آپ غیر انگریزی زبان بولتے ہیں یا تشریح میں مدد کی ضرورت ہے تو، زبان کی مدد کی خدمات اور مناسب معاون امداد آپ کے لئے مفت دستیاب ہیں۔ اگر آپ کو ان خدمات کی ضرورت ہے یا ہمارے منصوبے کے بارے میں سوالات ہیں تو، (TTY: 711) 1-800-353-3765 پر کال کریں۔

**Vietnamese:** Elderplan, Inc. tuân thủ luật dân quyền Liên bang hiện hành và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, tình trạng khuyết tật hoặc giới tính. CHÚ Ý: Nếu quý vị nói ngôn ngữ không phải tiếng Anh hoặc cần được hỗ trợ thông dịch thì chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các phương tiện phụ trợ phù hợp miễn phí cho quý vị. Nếu quý vị cần những dịch vụ này hoặc có thắc mắc về chương trình của chúng tôi, hãy gọi số 1-800-353-3765 (TTY: 711).

## Yiddish

Elderplan, Inc. פאָלגט די אָנווענדלעכע פעדעראלע ציווילע רעכט געזעצן און דיסקרימינירט נישט אויף דער באַזע פון ראַסע, קאָליר, נאַציאָנאַלער אָפּשטאַם, עלטער, דיסאַביליטי, אָדער געשלעכט. ופּמערקזאַמקייט: אויב איר רעדט אַ נישט-ענגלישע שפּראַך אָדער דאַרפֿט הילף מיט איבערזעצונג, זענען שפּראַך הילף באַדינונגען און פּאַסיק הילפּסמיטלען בנימצא פֿאַר אַיך אָן קיין אָפּצאַל. אויב איר דאַרפֿט די סערוויסעס אדער האָט פֿראַגעס וועגן אונדזער פּלאַן, רופֿט אָן 1-800-353-3765 (TTY: 711)