Elderplan Assist (HMO-POS IE-SNP) offered by Elderplan Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of Elderplan Assist (HMO IE-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.elderplan.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Elderplan Assist (HMO-POS IE-SNP).
- To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-353-3765 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week. This call is free.

- This information is available in different formats, including braille or other alternate formats at no cost if you need it. Please call Member Services at the number listed above if you need plan information in another format or language.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Elderplan Assist (HMO-POS 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 document says "we," "us," or "our", it means Elderplan Inc. When it says "plan" or "our plan," it means Elderplan Assist (HMO-POS 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.

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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs *for* Elderplan Assist (HMO-POS IE-SNP) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$38.00 for your Part D Premium	$34.50 for your Part D Premium
Part B Deductible	There is no Part B Deductible.	There is no Part B Deductible.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your in-network and out-of-network combined covered Part A and Part B services. (See Section 2.2 for details.)	**In-Network** $8,300	**In-Network and Out-of-Network Combined** $8,850

Cost	2023 (this year)	2024 (next year)
Doctor office visits	**In-Network** Primary care visits: You pay $0 Copayment per visit. **Out-of-Network** Primary care visits are <u>not</u> covered. **In-Network** Specialist visits: You pay $0 Copayment per visit. **Out-of-Network** Specialist visits are <u>not</u> covered.	**In-Network and Out-of-Network** Primary care visits: You pay $0 Copayment per visit. **In-Network and Out-of-Network** Specialist visits: You pay 20% Coinsurance per visit. Referrals may be required.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network** You pay these amounts for each benefit period: Days 1-6: $320 copayment each day. Day 7 and beyond: $0 copayment each day. Authorization is required. **Out-of-Network** Inpatient Hospital Stays are <u>not</u> covered.	**In-Network and Out-of-Network** In 2024 the amounts for each benefit period are: $1,632 deductible. Days 1-60: $0 copayment per day. Days 61-90: $408 copayment per day. Days 91 and beyond: $816 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime).

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (continued)		Beyond lifetime reserve days: you pay all costs. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: The Part D Deductible is $505 for Tier 4: Non-Preferred Drugs and Tier 5: Specialty Drugs, except for covered insulin products and most adult Part D vaccines. During the Initial Coverage Stage: **Standard Retail Cost Sharing (in-network) *Ω** Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:	Deductible: The Part D Deductible is $545 for Tier 4: Non-Preferred Drugs and Tier 5: Specialty Drugs, except for covered insulin products and most adult Part D vaccines. During the Initial Coverage Stage: **Standard Retail Cost Sharing (in-network) *Ω** Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	**Tier 1**: **Preferred Generic Drugs –** You Pay $4 copayment. **Tier 2: Generic Drugs** – You Pay $14 copayment. **Tier 3: Preferred Brand Drugs** – You Pay $47 copayment. **Tier 4: Non-Preferred Drugs** – You Pay 25% coinsurance.	**Tier 1**: **Preferred Generic Drugs –** You Pay $4 copayment. **Tier 2: Generic Drugs** – You Pay $14 copayment. **Tier 3: Preferred Brand Drugs** – You Pay $47 copayment. **Tier 4: Non-Preferred Drugs** – You Pay 25% coinsurance.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	**Tier 5: Non-Preferred Drugs** – You Pay 25% coinsurance. 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: **Tier 1**: **Preferred Generic Drugs –** Retail – You Pay $12 copayment.	**Tier 5: Non-Preferred Drugs** – You Pay 25% coinsurance. 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: **Tier 1**: **Preferred Generic Drugs –** Retail – You Pay $12 copayment.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	Mail Order – You Pay $8 copayment. **Tier 2: Generic Drugs** – Retail – You Pay $42 copayment. Mail Order – You Pay $28 copayment. **Tier 3: Preferred Brand Drugs** – Retail – You Pay $141 copayment. Mail Order – You Pay $94 copayment. **Tier 4: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance.	Mail Order – You Pay $8 copayment. **Tier 2: Generic Drugs** – Retail – You Pay $42 copayment. Mail Order – You Pay $28 copayment. **Tier 3: Preferred Brand Drugs** – Retail – You Pay $141 copayment. Mail Order – You Pay $94 copayment. **Tier 4: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	Mail Order – You Pay 25% coinsurance. **Tier 5: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance. *60-Days supply is also available for Standard Retail. †NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.	Mail Order – You Pay 25% coinsurance. **Tier 5: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance. *60-Days supply is also available for Standard Retail. †NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	**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. Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay	**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. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued) (See Section 2.5 for details.)	whichever of these is larger: a coinsurance equal to 5% of the cost of the drug, or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.) 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."

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from Elderplan Assist (HMO IE-SNP) to Elderplan Assist (HMO-POS IE-SNP).

We will mail you a new Elderplan member ID card. If you have questions, or if your Elderplan member ID card is damaged, lost, or stolen, call Customer Service at 1-800-353-3765 (TTY users should call 711) right away and we will send you a new card.

You will see the new plan name reflected on future communications where the plan name is referenced.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$38.00 for your Part D Premium	$34.50 for your Part D Premium

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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 reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount in-network and out-of-network combined. Your plan premium and your costs for prescription drugs do not count toward your in-network maximum out-of-pocket amount.	**In-Network:** $8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part Services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	**In-Network and Out-of-Network Combined:** $8,850 Once you have paid $8,850 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.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.elderplan.org. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider and Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) and pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Acupressure Services **And** **Acupuncture Services**	**In-Network** Acupressure Services are <u>not</u> covered. You pay $10 copayment for Acupuncture Services, limited to 20 visits annually. **Out-of-Network** Acupressure Services and Acupuncture Services are <u>not</u> covered.	**In-Network and Out-Of-Network** You pay no coinsurance or copayment for each visit. You may receive up to 20 visits for Acupressure Services and Acupuncture Services combined.

Cost	2023 (this year)	2024 (next year)
Acupuncture for chronic low back pain	**In-Network** You pay $10 copayment for Medicare-covered Acupuncture for chronic low back pain services.	**In-Network** You pay no coinsurance or copayment for Medicare-covered Acupuncture for chronic low back pain services.
Ambulance services	**In-Network** You pay $100 copayment for each one-way Ground Ambulance trip. You pay 20% coinsurance for each one-way Air Ambulance trip. Authorization is required for non-emergent services.	**In-Network** You pay 20% coinsurance for each one-way Ground Ambulance trip. You pay 20% coinsurance for each one-way Air Ambulance trip. Authorization is required for non-emergent services.

Cost	2023 (this year)	2024 (next year)
Cardiac Rehabilitation Services	**In-Network** You pay $40 copayment for Medicare-covered Cardiac Rehabilitation Services. You pay $60 copayment for Medicare-covered Intensive Cardiac Rehabilitation Services. Authorization is required.	**In-Network** You pay 20% coinsurance for Medicare-covered Cardiac Rehabilitation Services. You pay 20% coinsurance for Medicare-covered Intensive Cardiac Rehabilitation Services. Authorization is required.
Chiropractic services	**In-Network** You pay $20 copayment for Medicare-covered Chiropractic Services.	**In-Network and Out-of-Network** You pay 20% coinsurance for Medicare-covered Chiropractic Services.

Cost	2023 (this year)	2024 (next year)
Chiropractic services (continued)	**Out-of-Network** Chiropractic services are not covered.	
Dental services: Supplemental Preventive Dental Services	**In-Network** Supplemental Preventive Dental Services are not covered.	**In-Network** Coverage of Supplemental Preventive Dental Services is limited to selected service codes from the categories below. You pay $0 copayment for the following supplemental preventative dental services: • Limited Oral Exams: 1 every month • Oral Exams: 1 every 6 months

Cost	2023 (this year)	2024 (next year)
Dental services: Supplemental Preventive Dental Services (continued)		• Cleanings (Prophylaxis): 1 every 6 months • Dental X-Rays: 1 every 6 months • Complete Series Dental X-Rays: 1 every 36 months • Panoramic & Cephalometric Film: 1 every 36 months • Oral/Facial Photographic images: 2 every 6 months

Cost	2023 (this year)	2024 (next year)
Dental services: Supplemental Comprehensive Dental Services	**In-Network** Supplemental Comprehensive Dental Services are <u>not</u> covered.	**In-Network** Coverage of Supplemental Comprehensive Dental Services is limited to selected service codes from the categories below with an allowance of $1500 annually. Preventive Dental does not apply towards the annual maximum. Upon exhaustion of the $1500 annual benefit limit the member will be responsible for the full cost. Benefit frequency may be limited per ADA

Cost	2023 (this year)	2024 (next year)
Dental services: Supplemental Comprehensive Dental Services (continued)		guidelines to 1 service per tooth/per arch/per quadrant. <u>Restorative Services</u> Select Restoration Codes Only at $0 copayment /1 every 12 months, per tooth OR $0 copayment /1 every 60 months, per tooth. Select Major Restoratives Code Only at $0 copayment / 1 every 60 months, per tooth OR $0 copayment /1 per lifetime, per tooth Select codes are covered at $0 with no frequency limitation.

Cost	2023 (this year)	2024 (next year)
Dental services: Supplemental Comprehensive Dental Services (continued)		<u>Endodontic Services</u> Select Root Canal Therapy Codes Only at $0 copayment/1 per lifetime, per tooth. <u>Periodontics Services</u> Select Codes Only at $0 copayment / 1 every 36 months OR $0 copayment / 1 every 60 months. <u>Prosthodontics Services</u> Select Fixed Partial Denture Pontics Codes Only at $0 copayment / 1 every 60 months, per tooth.

Cost	2023 (this year)	2024 (next year)
Dental services: Supplemental Comprehensive Dental Services (continued)		Select Fixed Partial Denture per arch Retainers Crowns Codes Only at $0 copayment / 1 every 60 months, per tooth. Oral and Maxillofacial Surgery Select Codes Only at $0 copayment / 1 per lifetime, per tooth. For more information about which services are covered please contact Member Services.

Cost	2023 (this year)	2024 (next year)
Emergency care	You pay a $90 copayment for each Medicare-covered emergency room visit.	You pay 20% coinsurance (up to $100) for each Medicare-covered emergency room visit.
Hearing services	**In-Network** You pay no coinsurance or copayment for Medicare-covered diagnostic hearing exams.	**In-Network** You pay 20% coinsurance for Medicare-covered diagnostic hearing exams.
Home health agency care	**In-Network** You pay no coinsurance or copayment for Home Health Agency Care Services. Authorization is required.	**In-Network and Out-of-Network** You pay no coinsurance or copayment for Home Health Agency Care Services. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Home health agency care (continued)	**Out-of-Network** Home health agency care is <u>not</u> covered.	
Inpatient hospital stays	**In-Network** You pay these amounts for each benefit period: Days 1-6: $320 copayment each day. Day 7 and beyond: $0 copayment each day. Authorization is required.	**In-Network and Out-of-Network** In 2024 the amounts for each benefit period are: $1,632 deductible. Days 1-60: $0 copayment per day. Days 61-90: $408 copayment per day.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (continued)	**Out-of-Network** Inpatient hospital stays are not covered.	Days 91 and beyond: $816 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: you pay all costs. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay.	**In-Network** In 2023 the amounts for each benefit period are: Days 1-6: $300 copayment each day. Day 7 and beyond: $0 copayment each day. Authorization Required.	**In-Network** In 2024, the amounts for each benefit period are: $1,632 deductible. Days 1-60: $0 copayment per day. Days 61-90: $408 copayment per day. Days 91 and beyond: $816 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: you pay all costs.

Cost	2023 (this year)	2024 (next year)
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. **(continued)**		Authorization is required.
Medicare-covered Zero Dollar Preventive Services	**In-Network** You pay no coinsurance, copayment, or deductible for Medicare-covered Zero Dollar Preventive Services. **Out-of-Network** Medicare-covered Zero Dollar Preventive Services are not covered.	**In-Network and Out-of-Network** You pay no coinsurance, copayment, or deductible for Medicare-covered Zero Dollar Preventive Services.

Cost	2023 (this year)	2024 (next year)
Medicare-covered Preventive Services	**In-Network** You pay no coinsurance, copayment, or deductible for the following services: • Diabetes self-management training • Glaucoma tests	**In-Network and Out-of-Network** You pay 20% coinsurance for the following services: • Diabetes self-management training • Glaucoma tests

Cost	2023 (this year)	2024 (next year)
Outpatient Diagnostic Tests and Therapeutic Services	**In-Network** There is no coinsurance or copayment for the following Medicare-covered Services: • Lab Services • Diagnostic Procedures/ Tests. • X-Ray Services. Authorization may be required for certain x ray services. Referrals are not required. • Diagnostic Radiological Services.	**In-Network and Out-of-Network** There is no coinsurance or copayment for the following Medicare-covered Services: • Diagnostic Radiological Services. Authorization is required only for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT).

Cost	2023 (this year)	2024 (next year)
Outpatient Diagnostic Tests and Therapeutic Services (continued)	Authorization is required only for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT). You pay 20% coinsurance for each of the following Medicare-covered services: • Therapeutic Radiological Services.	You pay a $10 copayment for the following Medicare covered services: • Lab Services You pay 20% coinsurance for each of the following Medicare-covered services: • Diagnostic Procedures/ Tests. • Therapeutic Radiological Services. • X-Ray Services. Authorization may be required for certain x-ray services.

Cost	2023 (this year)	2024 (next year)
Outpatient Diagnostic Tests and Therapeutic Services (continued)	**Out-of-Network** Outpatient Diagnostic Tests and Therapeutic Services are not covered.	Referrals may be required.
Outpatient Hospital Observation	**In-Network** You pay $215 copayment for Medicare covered Outpatient Hospital Observation Services. **Out-of-Network** Outpatient hospital observation is not covered.	**In-Network and Out-of-Network** You pay 20% coinsurance for Medicare covered Outpatient Hospital Observation Services.

Cost	2023 (this year)	2024 (next year)
Outpatient Hospital Services	**In-Network** You pay $250 copayment for Outpatient Hospital Services. **Out-of-Network** Outpatient Hospital Services are not covered.	**In-Network and Out-of-Network** You pay 20% coinsurance for Outpatient Hospital Services.
Outpatient mental health care	**In Network** You pay 45% coinsurance for Medicare-covered Mental Health Specialty Individual or Group Sessions. Authorization is required.	**In-Network and Out-of-Network** You pay 20% coinsurance for Medicare-covered Mental Health Specialty Individual or Group Sessions. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Outpatient mental health care (continued)	You pay 45% coinsurance for Medicare-covered Psychiatric Individual or Group Sessions. **Out-of-Network** Outpatient mental health care is not covered.	You pay 20% coinsurance for Medicare-covered Psychiatric Individual or Group Sessions.
Outpatient rehabilitation services	**In-Network** You pay $30 copayment for Occupational Therapy, Physical Therapy, or Speech/Language Pathology services per visit. **Out-of-Network** Outpatient rehabilitation services are not covered.	**In-Network and Out-of-Network** You pay 20% coinsurance for Occupational Therapy, Physical Therapy, or Speech/Language Pathology services per visit.

Cost	2023 (this year)	2024 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay $250 copayment for Outpatient Surgery at an Outpatient Hospital. You pay $100 copayment for Outpatient Surgery at an Ambulatory Surgical Center. Referrals are <u>not</u> required. **Out-of-Network** Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers is <u>not</u> covered.	**In-Network and Out-of-Network** You pay 20% coinsurance for Outpatient Surgery at an Outpatient Hospital. You pay 20% coinsurance for Outpatient Surgery at an Ambulatory Surgical Center. Referral may be required.

Cost	2023 (this year)	2024 (next year)
Over the Counter (OTC)	You may purchase up to $26 every month of eligible OTC items. The OTC card balance cannot be carried over to the next month. Your OTC benefit covers COVID 19 tests at select pharmacies and/or retailers.	You may purchase up to $120 every month of eligible OTC items. The OTC card balance cannot be carried over to the next month. Your OTC benefit covers COVID 19 tests and Naloxone nasal spray at select pharmacies and/or retailers. The OTC benefit combines with Special Supplemental Benefits for the Chronically Ill (SSBCI) for eligible members.

Cost	2023 (this year)	2024 (next year)
Partial hospitalization services	**In-Network** You pay $55 copayment for Partial Hospitalization Services. Authorization is required.	**In-Network** You pay 20% coinsurance for Partial Hospitalization Services. Authorization is required.
Physician/ Practitioner services, including doctor's office visits	**In-Network** You pay no coinsurance or copayment for each office visits for the following services: • Primary Care Provider (PCP) Services. • Provider Specialist Services. Referrals are not required.	**In-Network and Out-of-Network** You pay no coinsurance or copayment for each office visits for the following service: • Primary Care Provider (PCP) Services. You pay 20% coinsurance or each office visits for the following services:

Cost	2023 (this year)	2024 (next year)
Physician/ Practitioner services, including doctor's office visits (continued)	• Other Health Care Professionals. Referrals are not required. **Out-of-Network** Physician/Practitioner services, including doctor's office visits are not covered.	• Other Health Care Professionals. Referrals may be required. • Provider Specialist Services. Referrals may be required.
Physician/ Practitioner services, including doctor's office visits - Telehealth Services	**In-Network** You pay the following cost shares for these Telehealth Services: • 20% coinsurance for Primary Care Provider (PCP) Services.	**In-Network** You pay the following cost shares for these Telehealth Services: • $0 copayment for Primary Care Provider (PCP) Services.

Cost	2023 (this year)	2024 (next year)
Physician/ Practitioner services, including doctor's office visits - Telehealth Services (continued)	• 20% coinsurance for Specialist Services. • $60 copayment for Urgently Needed Services. • 45% coinsurance for Mental Health Specialty Services (Individual and Group Sessions). • 45% coinsurance for Psychiatric Services (Individual and Group Sessions). • 20% coinsurance for Outpatient Substance Abuse (Individual and Group Sessions). Authorization is not required.	• 20% coinsurance for Specialist Services. • 20% coinsurance (up to $55) for Urgently Needed Services. • 20% coinsurance for Mental Health Specialty Services (Individual and Group Sessions). • 20% coinsurance for Psychiatric Services (Individual and Group Sessions).

Cost	2023 (this year)	2024 (next year)
Physician/ Practitioner services, including doctor's office visits - Telehealth Services (continued)		Authorization may be required for remote patient monitoring devices.
Podiatry - Medicare Covered	**In-Network** You pay $10 copayment for Medicare-covered Podiatry Services. **Out-of-Network** Medicare Covered podiatry is <u>not</u> covered.	**In-Network and Out-of-Network** You pay 20% coinsurance for Medicare-covered Podiatry Services.
Podiatry - Supplemental Podiatry Services	**In-Network** You pay a $10 copayment for Supplemental Podiatry Services. You may receive up to 6 Routine Foot Care visits per year.	**In-Network** Supplemental Podiatry Services are <u>not</u> covered.

Cost	2023 (this year)	2024 (next year)
Prosthetic devices and related supplies	**In-Network** You pay no coinsurance or copayment for Medicare-covered Medical Supplies. Authorization is required. You pay 20% coinsurance for Medicare covered Prosthetic Devices. Authorization is required.	**In-Network** You pay 20% coinsurance for Medicare-covered Medical Supplies. Authorization is required. You pay 20% coinsurance for Medicare covered Prosthetic Devices. Authorization is required.
Pulmonary rehabilitation services	**In-Network** You pay $20 copayment for Medicare-covered Pulmonary rehabilitation services. Authorization is required.	**In-Network** You pay 20% coinsurance for Medicare-covered Pulmonary rehabilitation services. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI)	Special Supplemental Benefit for the Chronically Ill (SSBCI) is not covered.	There is no coinsurance or copayment for Special Supplemental Benefits for the Chronically Ill. Members eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) will receive a combined OTC benefit to cover certain utility payments as a part of the monthly OTC allowance.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI) (continued)		The combined OTC coverage of up to $120 per month will be available monthly. Benefits will not carry forward to the next period if it is unused. Members not eligible for Special Supplemental Benefits for Chronically Ill (SSBCI) will only receive Over-the Counter Non-Prescription Drug Coverage.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI) (continued)		Contact the Plan for a complete listing of eligible items and network listing of select pharmacies and/or retailers.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**In-Network** You pay $25 copayment for each Medicare-covered SET (for PAD) session. Authorization is required.	**In-Network** You pay 20% coinsurance for each Medicare-covered SET (for PAD) session. Authorization is required.
Skilled Nursing Facility (SNF) Care	**In-Network** The plan covers up to 100 days each benefit period (a 3-day minimum prior hospital stay for a related illness or injury is NOT required).	**In-Network** The plan covers up to 100 days each benefit period (a 3-day minimum prior hospital stay for a related illness or injury is NOT required).

Cost	2023 (this year)	2024 (next year)
Skilled Nursing Facility (SNF) Care (continued)	In 2023, you pay per admission: Days 1-20: $0 per day. Days 21-100: $200 copayment per day. Days 101 and beyond: you pay all costs.	In 2024, you pay per admission: Days 1-20: $0 per day. Days 21-100: $204 copayment per day. Days 101 and beyond: you pay all costs.

Cost	2023 (this year)	2024 (next year)
Skilled Nursing Facility (SNF) Care (continued)	A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. Authorization is required.	A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. Authorization is required.

Cost	2023 (this year)	2024 (next year)
Transportation (Non-Medicare Covered)	There is no coinsurance or copayment for Non-Medicare Covered Transportation. You may take up to 12 one-way trips to a plan approved health-related locations per quarter (3 months) by Taxi, Bus, Subway, or Van. Any trips unused will not carry over to the following quarter.	There is no coinsurance or copayment for Non-Medicare Covered Transportation. You may receive unlimited one-way tips to plan approved health-related locations up to $1,000 per quarter (3 months) by Taxi, Rideshare Services, Bus/Subway, Van, and Medical Transport. You will receive a Pre-paid allowance card for non-Medicare covered Transportation services.

Cost	2023 (this year)	2024 (next year)
Transportation (Non-Medicare Covered)		Any unused benefit dollars will expire at the end of the quarter or if you disenroll from the plan. The non-Medicare covered Transportation card is only for personal use, it cannot be sold or transferred, and has no cash value.
Urgently needed services	You pay $60 copayment for each visit.	You pay 20% coinsurance (up to $55) for each visit.

Cost	2023 (this year)	2024 (next year)
Vision care	**In-Network** 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).	**In-Network and Out-of-Network** You pay 20% coinsurance for Medicare-covered preventative and diagnostic eye exams (including eye exams if you have diabetes, glaucoma tests, and macular degeneration tests and treatment).

Section 2.5 – Changes to Part D Prescription Drug Coverage

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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert with this packet, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	There is no Part D Deductible for Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, and Tier 3: Preferred Brand Drugs. The Part D Deductible is $505 for Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs. During this stage, you pay the full cost of your Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible.	There is no Part D Deductible for Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, and Tier 3: Preferred Brand Drugs. The Part D Deductible is $545 for Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs. During this stage, you pay full cost of your Tier 4: Non-Preferred Drugs and Tier 5: Specialty Tier Drugs until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.	**Standard Retail Cost Sharing (in-network) *Ω** Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage: **Tier 1: Preferred Generic Drugs –** You Pay $4 copayment. **Tier 2: Generic Drugs –** You Pay $14 copayment.	**Standard Retail Cost Sharing (in-network) *Ω** Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage: **Tier 1: Preferred Generic Drugs –** You Pay $4 copayment. **Tier 2: Generic Drugs –** You Pay $14 copayment.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) For information about the costs for a long-term supply; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	**Tier 3: Preferred Brand Drugs** – You Pay $47 copayment. **Tier 4: Non-Preferred Drugs** – You Pay 25% coinsurance. **Tier 5: Non-Preferred Drugs** – You Pay 25% coinsurance.	**Tier 3: Preferred Brand Drugs** – You Pay $47 copayment. **Tier 4: Non-Preferred Drugs –** You Pay 25% coinsurance. **Tier 5: Non-Preferred Drugs –** You Pay 25% coinsurance.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	Your cost for an **extended supply (up to 90-days)†Ω**	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:	filled at a network pharmacy with standard cost sharing during the Initial Coverage Stage:
	Tier 1: **Preferred Generic Drugs –**	**Tier 1: Preferred Generic Drugs**–
	Retail – You Pay $12 copayment.	Retail – You Pay $12 copayment.
	Mail Order – You Pay $8 copayment.	Mail Order – You Pay $8 copayment.
	Tier 2: Generic Drugs –	**Tier 2: Generic Drugs** –
	Retail – You Pay $42 copayment.	Retail – You Pay $42 copayment.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	Mail Order – You Pay $28 copayment.	Mail Order – You Pay $28 copayment.
	Tier 3: Preferred Brand Drugs –	**Tier 3: Preferred Brand Drugs** –
	Retail – You Pay $141 copayment.	Retail – You Pay $141 copayment.
	Mail Order – You Pay $94 copayment.	Mail Order – You Pay $94 copayment.
	Tier 4: Non-Preferred Drugs –	**Tier 4: Non-Preferred Drugs** –
	Retail – You Pay 25% coinsurance.	Retail – You Pay 25% coinsurance.
	Mail Order – You Pay 25% coinsurance.	Mail Order – You Pay 25% coinsurance.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance. *60-Days supply is also available for Standard Retail. †NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.	**Tier 5: Non-Preferred Drugs** – Retail – You Pay 25% coinsurance. Mail Order – You Pay 25% coinsurance. *60-Days supply is also available for Standard Retail. †NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**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. 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."	**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. 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."

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Elderplan Assist (HMO-POS IE-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Elderplan Assist (HMO-POS IE-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, Elderplan Inc. offers other Medicare health plans.

These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Elderplan Assist (HMO-POS IE-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Elderplan Assist (HMO-POS IE-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of 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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HIICAP at (212) 602-4180 inside the boroughs or 1-800-701-0501 outside the boroughs. You can learn more about HIICAP by visiting their website (https://aging.ny.gov/programs/medicare-and-healthinsurance).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York State 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.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

SECTION 7 Questions?

Section 7.1 – Getting Help from Elderplan Assist (HMO-POS IE-SNP)

Questions? We're here to help. Please call Member Services at 1-800-353-3765. (TTY only, call 711). We are available for phone calls 8 am to 8 pm, 7 days a week. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Elderplan Assist (HMO-POS IE-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.elderplan.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.elderplan.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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 should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

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
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.

OMB Approval 0938-1051 (Expires: February 29, 2024)

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-353-3765 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-353-3765 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Simplified: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-353-3765 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Traditional: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-353-3765 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-353-3765 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-353-3765 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-353-3765 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-353-3765 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-353-3765 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-353-3765 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على 1-800-353-3765 (TTY:711). سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-353-3765 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-353-3765 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-353-3765 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-353-3765 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-353-3765 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-353-3765 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Albanian: Ne ofrojmë shërbime interpretimi pa pagesë për t'ju përgjigjur çdo lloj pyetjeje që mund të keni rreth planit tonë të shëndetit ose të mjekimit. Për t'u lidhur me një interpret, telefononi në 1-800-353-3765 (TTY: 711). Një shqip folës mund t'ju ndihmojë. Ky shërbim është pa pagesë.

Bengali: আমাদের স্বাস্থ্য বা ওষুধপত্র বিষয়ক পরিকল্পনা সম্পর্কিত আপনার যে কোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা রয়েছে। একজন দোভাষী পেতে, আমাদের কেবল 1-800-353-3765 (TTY: 711) নম্বরে কল করুন। বাংলা বলতে পারেন এমন কেউ আপনাকে সাহায্য করতে পারবেন। পরিষেবাটি বিনামূল্যে।

Greek: Διαθέτουμε υπηρεσία δωρεάν διερμηνείας προκειμένου να απαντούμε σε οποιεσδήποτε απορίες σας σχετικά με το πρόγραμμα υγείας ή φαρμάκων που προσφέρουμε. Προκειμένου να χρησιμοποιήσετε την υπηρεσία διερμηνείας, επικοινωνήστε μαζί μας καλώντας το 1-800-353-3765 (TTY: 711). Θα λάβετε βοήθεια από ένα άτομο που μιλά ελληνικά. Αυτή είναι μια υπηρεσία που παρέχεται δωρεάν.

Yiddish: מיר האבן אומזיסטע דאלמעטשער סערוויסעס צו ענטפערן סיי וועלכע פראגעס וואס איר קענט מעגליך האבן וועגן 1-800-353-3765 (TTY:711) איינער וואס אונזער העלט אדער דראג פלאן. צו באקומען א דאלמעטשער, רופט אונז אויף רעדט אידיש/שפראך קען אייך העלפן. דאס איז אן אומזיסטע סערוויס.

Urdu: ہماری صحت یا دوا کے پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات موجود ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں بس 1-800-353-3765 (TTY: 711) پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت خدمت ہے۔