Elderplan Select (HMO-POS I-SNP/IE-SNP) offered by *Elderplan Inc.*

Annual Notice of Changes for 2025

You are currently enrolled as a member of Elderplan Select (HMO-POS I-SNP/IE-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 7 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Elderplan Select (HMO-POS I-SNP/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 a.m. to 8 p.m., 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 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 document 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.

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Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Elderplan Select (HMO-POS I-SNP/IE-SNP) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	You do not pay a Part D Premium.	You do not pay a Part D Premium. There is no change for 2025.

Cost	2024 (this year)	2025 (next year)
Monthly Part B Premium Reduction (If you pay your Part B premium through Social Security, the Part B Giveback will be credited monthly to your Social Security check.) (If you don't pay your Part B premium through Social Security, you'll pay a reduced monthly amount directly to Medicare.)	Not Covered	$2.50
Part B Deductible	There is no Part B Deductible.	There is no Part B Deductible. There is no change for 2025.

Cost	2024 (this year)	2025 (next year)
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 and Out-of-Network Combined** $8,850	**In-Network and Out-of-Network Combined** $7,500

Cost	2024 (this year)	2025 (next year)
Doctor office visits	**In-Network and Out-of-Network** Primary care visits: You pay $0 Copayment per visit.	**In-Network and Out-of-Network** Primary care visits: You pay $0 Copayment per visit. There is no change for 2025.
	In-Network and Out-of-Network Specialist visits: You pay $45 Copayment per visit. Referrals may be required.	**In-Network and Out-of-Network** Specialist visits: You pay $45 Copayment per visit. Referrals may be required. You pay $0 copayment per office visit for: • Endocrinologist. Referrals may be required.

Cost	2024 (this year)	2025 (next year)
Doctor office visits (continued)		• Urologist. Referrals may be required.
Inpatient hospital stays	**In-Network and Out-of-Network** You pay per admission: Days 1-6: $320 copayment each day Day 7 and beyond: $0 copayment each day Authorization Required	**In-Network and Out-of-Network** You pay per admission: Days 1-6: $320 copayment each day Day 7 and beyond: $0 copayment each day Authorization Required There is no change for 2025.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	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.	Deductible: The Part D Deductible is $0.
	During the Initial Coverage Stage:	During the Initial Coverage Stage:
	Standard Retail Cost Sharing (in-network) *Ω	**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:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing during the initial coverage stage:

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	**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 5: Non-Preferred Drugs –** You Pay 25% coinsurance.	**Tier 1**: **Preferred Generic Drugs –** You Pay $0 copayment. **Tier 2: Generic Drugs –** You Pay $2 copayment. **Tier 3: Preferred Brand Drugs –** You Pay $25 copayment. **Tier 4: Non-Preferred Drugs –** You Pay $100 copayment **Tier 5: Non-Preferred Drugs –** You Pay 25% coinsurance.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	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. Mail Order – You Pay $8 copayment. **Tier 2: Generic Drugs –** Retail – You Pay $42 copayment.	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 $0 copayment. Mail Order – You Pay $0 copayment. **Tier 2: Generic Drugs –** Retail – You Pay $6 copayment.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	Mail Order – You Pay $28 copayment.	Mail Order – You Pay $4 copayment.
	Tier 3: Preferred Brand Drugs –	**Tier 3: Preferred Brand Drugs –**
	Retail – You Pay $141 copayment.	Retail – You Pay $75 copayment.
	Mail Order – You Pay $94 copayment.	Mail Order – You Pay $50 copayment.
	Tier 4: Non-Preferred Drugs –	**Tier 4: Non-Preferred Drugs –**
	Retail – You Pay 25% coinsurance.	Retail – You Pay $300 copayment.
	Mail Order – You Pay 25% coinsurance.	Mail Order – You Pay $200 copayment.
	Tier 5: Non-Preferred Drugs –	**Tier 5: Non-Preferred Drugs –**
	Retail – You Pay 25% coinsurance.	Retail – You Pay 25% coinsurance.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	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. 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."	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. 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."

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (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. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	**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, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (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 2025.
Monthly Part B Premium Reduction (If you pay your Part B premium through Social Security, the Part B Giveback will be credited monthly to your Social Security check.) (If you don't pay your Part B premium through Social Security, you'll pay a reduced monthly amount directly to Medicare.)	Not Covered	$2.50

- 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.

Section 1.2 – 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	2024 (this year)	2025 (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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**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	**In-Network and Out-of-Network Combined** $7,500 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.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may 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.

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 and pharmacies for next year. **Please review the 2025 *Provider and Pharmacy Directory* *www.elderplan.org* 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 1.4 – 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	2024 (this year)	2025 (next year)
Cardiac Rehabilitation Services	**In-Network** You pay $30 copayment for Medicare covered Cardiac Rehabilitation Services. You pay $55 copayment for Medicare covered Intensive Cardiac Rehabilitation Services. Authorization is required.	**In-Network** You pay $35 copayment for Medicare covered Cardiac Rehabilitation Services. You pay $45 copayment for Medicare covered Intensive Cardiac Rehabilitation Services. Authorization is required.

Cost	2024 (this year)	2025 (next year)
Supplemental Preventive and Comprehensive Dental Services	Dental Services not covered in 2024.	There is no coinsurance or copayment for Supplemental Preventive and Comprehensive Dental Services. You may receive unlimited Supplemental Preventive and Comprehensive Dental Services up to $1,500 every year. Eligible dental services are: • Oral Exams • Dental X-Rays • Other Diagnostic • Dental Services • Prophylaxis (cleaning)

Cost	2024 (this year)	2025 (next year)
Supplemental Preventive and Comprehensive Dental Services (continued)		• Fluoride Treatment • Other Preventive Dental Services • Restorative Services • Endodontics • Periodontics • Prosthodontics, removable • Maxillofacial Prosthetics • Implant Services • Prosthodontics, fixed • Oral and Maxillofacial Surgery • Orthodontics • Adjunctive General Services

Cost	2024 (this year)	2025 (next year)
Supplemental Preventive and Comprehensive Dental Services (continued)		You will receive a Prepaid allowance card for Supplemental Preventive and Comprehensive Dental Services. Any unused benefit dollars will expire at the end of the calendar year or if you disenroll from the plan. The Supplemental Preventive and Comprehensive Dental Services card is only for personal use, it cannot be sold or transferred, and has no cash value.

Cost	2024 (this year)	2025 (next year)
Durable Medical Equipment and related supplies	**In-Network** You pay 20% coinsurance for Medicare covered Durable Medical Equipment (DME) and Related Supplies. Authorization is only required for certain items that are like but not limited to high dollar, motorized, and custom equipment or items.	**In-Network** You pay 20% coinsurance for Medicare covered Durable Medical Equipment (DME) and Related Supplies. Authorization is only required for certain items that are like but not limited to high dollar, motorized, and custom equipment or items.

Cost	2024 (this year)	2025 (next year)
Durable Medical Equipment and related supplies (continued)		You pay $0 copayment for Freestyle Libre Continuous Glucose Monitors and supplies that are available at participating pharmacies. Authorization is required.
Emergency care	You pay $100 copayment for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, there is no cost-sharing.	You pay $110 copayment for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 hours for the same condition, there is no cost-sharing.

Cost	2024 (this year)	2025 (next year)
Medicare Part B prescription drugs	**In-Network** You pay 20% coinsurance or copayment Medicare Part B prescription drugs. You pay up to $35 for Medicare Part B Insulin Drugs. Medicare Part B Prescription Drugs may be subject to step therapy requirements. Authorization may be required for certain drugs.	**In-Network** You pay 20% coinsurance or copayment Medicare Part B prescription drugs. You pay up to $35 for Medicare Part B Insulin Drugs. Medicare Part B Prescription Drugs is NOT subject to Step therapy requirements. Authorization may be required for certain drugs.

Cost	2024 (this year)	2025 (next year)
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	**In-Network and Out-of-Network** You pay 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. Referral may be required.	**In-Network and Out-of-Network** You pay 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. Referral may be required. • CAT Scans (CT) Services. Authorization is required.

Cost	2024 (this year)	2025 (next year)
Outpatient Diagnostic Tests and Therapeutic Services and Supplies (continued)	You pay $75 copayment for the following Medicare covered services: • Therapeutic Radiological 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).	You pay $75 copayment for the following Medicare covered services: • Therapeutic Radiological Services. • Diagnostic Radiological Services. Authorization is required only for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA).

Cost	2024 (this year)	2025 (next year)
Outpatient mental health care	**In-Network and Out-of-Network** You pay $45 copayment for Medicare-covered Mental Health Specialty Individual or Group Sessions. Authorization is required. You pay $45 copayment for Medicare covered Psychiatric Individual and Group sessions.	**In-Network and Out-of-Network** You pay $50 copayment for Medicare-covered Mental Health Specialty Individual or Group Sessions. Authorization is required. You pay $45 copayment for Medicare covered Psychiatric Individual and Group sessions.

Cost	2024 (this year)	2025 (next year)
Outpatient rehabilitation services	**In-Network and Out-of-Network** You pay $40 copayment for Occupational Therapy per visit. You pay $40 copayment for Physical Therapy or Speech/Language Pathology Services per visit.	**In-Network and Out-of-Network** You pay $35 copayment for Occupational Therapy per visit. You pay $40 copayment for Physical Therapy or Speech/Language Pathology Services per visit.

Cost	2024 (this year)	2025 (next year)
Over the Counter (OTC)	You may purchase up to $110 every month of eligible OTC items. The OTC card balance cannot be carried over to the next month. The OTC benefit combines with Special Supplemental Benefits for the Chronically Ill (SSBCI) for eligible members. Your OTC benefit covers COVID 19 tests and Naloxone nasal spray at select pharmacies and/or retailers.	You may purchase up to $175 every month of eligible OTC items. The OTC card balance cannot be carried over to the next month. The OTC benefit combines with Special Supplemental Benefits for the Chronically Ill (SSBCI) for eligible members. Your OTC benefit covers COVID 19 tests and Naloxone nasal spray at select pharmacies and/or retailers.

Cost	2024 (this year)	2025 (next year)
Physician/ Practitioner Services - Telehealth Services	**In-Network** You pay the following cost shares for these Telehealth Services: • $0 copayment for Primary Care Provider (PCP) Services. • $0 copayment for Urgently Needed Services • $45 copayment for Specialist Services. • $45 copayment for Mental Health Specialty Services (Individual and Group Sessions).	**In-Network** You pay the following cost shares for these Telehealth Services: • $0 copayment for Primary Care Provider (PCP) Services. • $45 copayment for Urgently Needed Services • $45 copayment for Specialist Services. • $50 copayment for Mental Health Specialty Services (Individual and Group Sessions).

Cost	2024 (this year)	2025 (next year)
Physician/ Practitioner services, including doctor's office visits - Telehealth Services (continued)	• $45 copayment for Psychiatric Services (Individual and Group Sessions).	• $45 copayment for Psychiatric Services (Individual and Group Sessions).
Pulmonary rehabilitation services	**In-Network** You pay $15 copayment for Medicare covered Pulmonary Rehabilitation Services. Authorization is required.	**In-Network** You pay $25 copayment for Medicare covered Pulmonary Rehabilitation Services. Authorization is required.

Cost	2024 (this year)	2025 (next year)
Services to treat kidney disease	**In-Network** You pay $45 copayment for the following services (to treat Kidney Disease): • Dialysis Services. You pay 20% coinsurance for the following services (to treat Kidney Disease): • Kidney Disease Education Services.	**In-Network** You pay $55 copayment for the following services (to treat Kidney Disease): • Dialysis Services. You pay 20% coinsurance for the following services (to treat Kidney Disease): • Kidney Disease Education Services.

Cost	2024 (this year)	2025 (next year)
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). You pay per admission: • Days 1-20: $0 copayment each day • Days 21-100: $203 copayment each day • Days 101 and beyond: you pay all cost Authorization is 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). You pay per admission: • Days 1-20: $0 copayment each day • Days 21-100: $214 copayment each day • Days 101 and beyond: you pay all cost Authorization is required.

Cost	2024 (this year)	2025 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI)	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.	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, home delivered meals, groceries and personal hygiene products as a part of the monthly OTC allowance.

Cost	2024 (this year)	2025 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI) (continued)	The combined OTC coverage of up to $110 per month will be available monthly. Benefits will not carry forward to the next period if it is unused. Contact the Plan for a complete listing of eligible items and network listing of select pharmacies and/or retailers.	The combined OTC coverage of up to $175 per month will be available monthly. Benefits will not carry forward to the next period if it is unused. Contact the Plan for a complete listing of eligible items and network listing of select pharmacies and/or retailers.
Supervised Exercise Therapy (SET)	**In-Network** You pay $25 copayment for each Medicare-covered SET (for PAD) session. Authorization is required.	**In-Network** You pay $20 copayment for each Medicare-covered SET (for PAD) session. Authorization is required.

Cost	2024 (this year)	2025 (next year)
Urgently needed services	You pay $0 copayment for each visit.	You pay $45 copayment for each visit.

Section 1.5 – 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, we might make other changes that are allowed by Medicare rules that will affect you during the plan 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 are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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 didn't receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **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 will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the 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 do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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 $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.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (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**.	**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 $0 copayment. **Tier 2: Generic Drugs –** You Pay $2 copayment.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued) Most adult Part D vaccines are covered at no cost to you.	**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 _____ 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 3: Preferred Brand Drugs –** You Pay $25 copayment. **Tier 4: Non-Preferred Drugs –** You Pay $100 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:

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 1: Preferred Generic Drugs–** Retail – You Pay $12 copayment. 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 1: Preferred Generic Drugs–** Retail – You Pay $0 copayment. Mail Order – You Pay $0 copayment. **Tier 2: Generic Drugs** – Retail – You Pay $6 copayment. Mail Order – You Pay $4 copayment. **Tier 3: Preferred Brand Drugs –** Retail – You Pay $75 copayment. Mail Order – You Pay $50 copayment.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4: Non-Preferred Drugs –** Retail – You Pay 25% coinsurance. 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.	**Tier 4: Non-Preferred Drugs –** Retail – You Pay $300 copayment Mail Order – You Pay $200 copayment **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.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill. **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.	†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill. **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.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	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."
	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-866-490-2102 (TTY 711) or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Elderplan Select (HMO-POS I-SNP/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 Select (HMO-POS I-SNP/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 2025 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 1.1 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 2025* 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 Select (HMO-POS I-SNP/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 Select (HMO-POS I-SNP/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, 2025.

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, 2025, 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, 2025.

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 (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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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 1-212-602-4180 inside the NYC boroughs or 1-800-701-0501 outside the NYC boroughs. You can learn more about HIICAP by visiting their website (https://aging.ny.gov/programs/medicare-and-health-insurance).

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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.

- **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. To be eligible for the ADAP operating in your State, 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 (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program or, if you are currently enrolled, how to continue receiving assistance, 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 new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug

coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).

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 this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-866-490-2102 (TTY: 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Elderplan Select (HMO-POS I-SNP/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 *2025 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 2025. For details, look in the *2025*

Evidence of Coverage for Elderplan Select (HMO-POS I-SNP/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 2025*

Read the *Medicare & You 2025* 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.

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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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 1-877-891-6447 (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、1-877-891-6447 (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 1-877-891-6447 (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 রয়েছে৷ একজন দোভাষী পেতে, আমাদের কেবল 1-877-891-6447 (TTY: 711) নম্বরে কল করুন৷ বাংলা বলতে পারেন এমন কেউ আপনাকে সাহায্য করতে পারবেন৷ পরিষেবাটি বিনামূল্যে৷

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 1-877-891-6447 (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 אונזער העלט אדער דראג פלאן. צו באקומען א דאלמעטשער, רופט אונז אויף 1-877-891-6447 (TTY:711) . איינער וואס 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 1-877-891-6447 (TTY:711) پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت خدمت ہے۔