2026

elderplan

Leading the way to great care.℠

Summary of Benefits

Elderplan Extra Help (HMO-POS)

January 1, 2026 to December 31, 2026

H3347_EP17980_M

Proposed Effective Date ____/____/_____

Primary Care Provider

Name _____

Address_____

Phone Number (_____) _____

Name of Sales Representative

_____

Important Numbers

_____

_____

_____

Member Services

1-800-353-3765, TTY **711**
8 a.m. to 8 p.m., 7 days a week

elderplan®

Summary of Benefits

for **Elderplan Extra Help (HMO-POS)**

January 1, 2026 – December 31, 2026

Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond and Westchester

About Elderplan

Elderplan is a participating agency of MJHS Health System. Both Elderplan and MJHS are not-for-profit organizations that share the same core values of compassion, dignity and respect.

Elderplan has a rich history of caring for at-risk New Yorkers of all backgrounds. That's why we understand that gaps in access to quality health care are still all too often a factor. Consistent with our values, we are ***leading the way to great care*** by being committed to health equity, to closing these gaps in care, and ensuring that all our members have access to high-quality programs and services.

In addition, an advantage to our members of Elderplan/HomeFirst being a participating agency of MJHS is that our health system also includes: MJHS Home Care, MJHS Hospice and Palliative Care, as well as MJHS Isabella and MJHS Menorah Centers for Rehabilitation and Nursing Care. So, should you require access to additional support over time, and choose to receive services from MJHS, the Elderplan team can work together with their colleagues from across the system to better coordinate your care.

Elderplan Extra Help (HMO-POS)

Plan Overview

A health plan designed for Medicare beneficiaries who are eligible for Extra Help—a federal program that lowers the cost of prescription drugs for people with limited income.

This plan offers medical, hospital, and prescription drug coverage at little-or-no premium and low copays. You can see any dentist or specialist in or out-of-network and take advantage of a quarterly OTC benefit. In addition, you'll also receive a Flex card to help cover out-of-pocket expenses for dental, vision, hearing, and fitness services.

This plan includes comprehensive dental coverage—with a larger network of providers through our new dental partner—so you can get the care you need more easily.

You'll have the support of a dedicated care management team, enjoy a gym membership to stay active, earn rewards through our Wellness Incentive Program, and have access to our award-winning Member-to-Member program.

Elderplan. Leading the way to great care.

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Benefits at a Glance

Freedom to choose any specialist or dentist in and out-of-network	**$0**
Doctor Visits (Primary Care)	
Part B Deductible	
Expanded Acupuncture	
Brain Games with BrainHQ®	
Supplemental Diagnostic and Preventive and Comprehensive Dental	
Routine Hearing	
Routine Vision	
Silver&Fit® Fitness Program	
Transportation	
24/7 Access to Care with Teladoc®	
Specialist Care	**$35**
Routine Podiatry	
Flex Card‡	**$450** every year
Over-the-Counter (OTC) Benefits	**$140** every quarter

Use your OTC benefit to purchase health related items, groceries, and meals too!*

*Eligibility is determined by whether you have a chronic condition associated with SSBCI benefit (expanded OTC). Examples of SSBCI conditions include, but are not limited to, Cardiovascular Disorders, Diabetes, Arthritis, Chronic Lung Disorders and Chronic Kidney Disease. There are other eligible conditions not listed. Standards may vary for this benefit.

‡Flex Card benefit offers $450 allowance Card to use in 2026 on out-of-pocket costs for dental, vision, hearing, and/or fitness services.

Section I: Introduction to Summary of Benefits

Elderplan is an HMO plan with Medicare and Medicaid contracts. 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 if not otherwise paid for under Medicaid or a third party.

This booklet gives you a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, see the 2026 Elderplan Extra Help (HMO-POS) Evidence of Coverage. A copy of the Evidence of Coverage is located on our website at **www.elderplan.org**.

Elderplan Contact Information

Elderplan Extra Help hours of operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern Time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern Time.

Elderplan Extra Help phone numbers and website

- If you are a member of this plan, call toll-free **1-800-353-3765**. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- If you are not a member of this plan, call toll-free **1-866-695-8101**. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- Our website: **www.elderplan.org**.

This document is available for free in Spanish and Chinese. 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 information is also available in different formats, including Braille or other alternate formats. Please call Member Services at the number listed above if you need plan information in another format or language.

Who Can Join?

To join Elderplan Extra Help (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Our service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond and Westchester counties.

Useful Information About Medicare

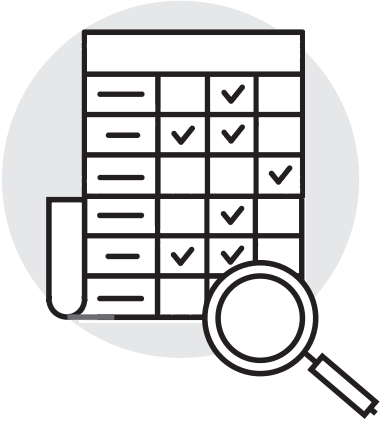
You have choices about how to get your Medicare Benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government. Visit the Medicare website (**www.medicare.gov**).
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Elderplan Extra Help (HMO-POS)).

Tips for Comparing your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Elderplan Extra Help (HMO-POS) covers and what you pay.

- You can compare Elderplan Extra Help and Original Medicare using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers. Our members receive all of the benefits that Original Medicare offers. The covered benefits may change from year to year.



- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at **https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **www.medicare.gov/plan-compare**.

Information About Elderplan Extra Help

Eligibility requirements for our plan

- Must have Medicare Part A and Medicare Part B.
- Must reside in the plan's service area: Bronx, Kings, Nassau, New York, Putnam, Queens, Richmond and Westchester counties.
- Must be a United States citizen or lawfully present in the United States.

Which Doctors, Hospitals and Pharmacies can I use?

Elderplan Extra Help (HMO-POS) has a network of doctors, hospitals, pharmacies and other providers. Our plan allows you to see In-Network and Out-of-Network providers based on our expansive benefit offering. Our plan covers services and benefits from any of our network providers listed in our Provider and Pharmacy Directory. Our plan also includes point-of-service coverage for certain services and benefits from any Medicare-certified provider who has not opted out of Medicare. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's Provider and Pharmacy Directory at our website **www.elderplan.org**, or call us and we will send you a copy of the Provider and Pharmacy Directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and more.

- Members get all of the benefits covered by Original Medicare.
- Members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

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

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **www.elderplan.org** or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

The amount you pay for drugs depends on the drug you are taking, what "drug payment stage" you have reached, and the plan cost-sharing tiers.

Later in this document we discuss the drug payment stages and the plan cost-sharing tiers. The drug payment stages are the Deductible Stage, Initial Coverage Stage, and Catastrophic Coverage Stage.

Every drug on the plan's Drug List is in one of five cost-sharing tiers:

- Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
- Tier 2: Generic Drugs
- Tier 3: Preferred Brand Drugs
- Tier 4: Non-preferred Drugs
- Tier 5: Specialty Tier Drugs (highest cost-sharing tier)

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see the Evidence of Coverage (Chapter 2, Section 7).

Section II: Summary of Benefits

The following are the health care costs for Elderplan Extra Help.

Elderplan Extra Help (HMO-POS)		
Monthly Premium (Part D Premium)	$58.80	In addition, you must keep paying your Medicare Part B premium.
Part B Deductible	$0	
Combined Maximum Out - of - Pocket	$7,550 In-Network and Out-of Network Combined	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on in-network and out-of network combined out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your plan premium, and any cost-sharing for your Part D prescription drugs.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need hospital care	Inpatient Hospital Services	You pay per admission: • Days 1–5: $425 copayment each day. • Day 6 and beyond: $0 copayment each day.	Authorization is required.
	Outpatient Hospital Services	20% coinsurance.	
	Ambulatory Surgical Center (ASC)	20% coinsurance.	
You want to see a doctor	Primary Care Providers	$0 copayment for office visits and telehealth services.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Specialists	**In-Network** $35 copayment for office visits. $10 copayment for telehealth services. **Out-of-Network** $35 copayment for office visits.	Please call your current provider for telehealth services details.
	Nurse Practitioners and Physician Assistants	**In-Network** $35 copayment for office visits. **Out-of-Network** $35 copayment for office visits.	Authorization only required for in-home visits.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care	$0 copayment for Annual Physical Exam.	This exam is covered in addition to the "Welcome to Medicare Exam" and Yearly "Wellness" Visit.
		$0 copayment.	Preventive care services may be covered by Medicare during the benefit year.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care *(continued)*	• Abdominal aortic aneurysm screening • Alcohol misuse screenings & counseling • Bone mass measurements • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screening • Colorectal cancer screenings - Blood-based biomarker tests - Colonoscopies - Computed tomography (CT) colonography - Flexible sigmoidoscopies - Fecal occult blood tests - Multi-target stool DNA tests • Counseling to prevent tobacco use & tobacco-caused disease • Depression screenings • Diabetes screenings • Diabetes self-management training • Glaucoma screenings • Hepatitis B shots • Hepatitis B Virus (HBV) infection screenings	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You want to see a doctor *(continued)*	Preventive Care *(continued)*	• Hepatitis C virus screenings • HIV screenings • Lung cancer screenings • Mammograms (screening) • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Obesity behavioral therapy • One-time "Welcome to Medicare" preventive visit • Pre-exposure prophylaxis (PrEP) for HIV prevention • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings & counseling • Shots: - COVID-19 vaccines - Flu shots - Hepatitis B shots - Pneumococcal shots • Yearly "Wellness" Visit	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You Need Emergency Care	Emergency Care	$110 copayment for each Medicare-covered emergency room visit.	If you are admitted to the hospital within 24 hours there is no cost share.
	Urgent Care	$35 copayment for office visits. $10 copayment for telehealth services.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need medical tests	Diagnostic Services/ Labs/Imaging • Medicare-covered Lab Services • Outpatient Blood Services	$0 copayment for each service.	
	Diagnostic Services/ Labs/Imaging • Diagnostic tests and Procedures	$35 copayment for each service.	

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need medical tests *(continued)*	Diagnostic Services/ Labs/Imaging • Outpatient X-rays	$20 copayment for each service.	
	Diagnostic Services/ Labs/Imaging • Therapeutic radiology services (such as radiation treatment for cancer) • Diagnostic Radiological services (such as MRI scans and CT scans)	20% coinsurance for each service.	Authorization is required only for Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and CAT Scan (CT).

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Hearing Care	Hearing Exams	$35 copayment for each Medicare-covered diagnostic hearing exams.	
		$0 copayment for one Non-Medicare-covered (Routine) Hearing Exam every 3 years.	
	Hearing Aids	Up to $500 maximum benefit every 3 years for one ear. $0 copayment for Fitting/Evaluation for Hearing Aid every 3 years. This benefit can only be used for one ear.	Authorization is required for hearing aid(s) by a Physician or Specialist.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Dental Care	Diagnostic and Preventive Dental Services	$0 for coverage of Supplemental Diagnostic and Preventive Dental Services are limited to selected service codes from the categories below In and Out-of-Network combined.	
	Comprehen-sive Dental Services	Coverage of Supplemental Comprehensive Dental Services are limited to selected service codes from the categories below In and Out-of-Network combined.	Supplemental Comprehensive Dental Services. Benefit frequency may be limited per American Dental Association guidelines.
		20% coinsurance for Medicare-covered Comprehensive Dental Services.	

Supplemental Preventive & Comprehensive Dental Services

In-Network and Out-of-Network

Covered Services	Copayment	Frequency
Supplemental Diagnostic & Preventive Dental Services		
Oral Exams		
Periodic oral evaluation - established patient	No charge	Once every 6 months
Limited oral evaluation-problem focused	No charge	Once every 6 months
Comprehensive oral evaluation - new or established patient	No charge	Once every 6 months
Detailed and extensive oral eval-problem focused, by report	No charge	Once every 6 months
Re-evaluation	No charge	Once every 6 months
Comprehensive periodontal evaluation	No charge	Once every 6 months
Dental X-Rays		
Intraoral - comprehensive series of radiographic images	No charge	Once every 36 months
Intraoral - periapical first radiographic image	No charge	Once every 12 months

Dental X-Rays		
Intraoral - periapical each additional radiographic image	No charge	Once every 12 months
Intraoral - occlusal radiographic image	No charge	Once every 12 months
Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No charge	Once every 12 months
Bitewing - single radiographic image	No charge	Once every 12 months
Bitewings - two radiographic images	No charge	Once every 12 months
Bitewings - three radiographic images	No charge	Once every 12 months
Bitewings - four radiographic images	No charge	Once every 12 months
Vertical bitewings - 7 to 8 films	No charge	Once every 12 months
Panoramic film	No charge	Once every 12 months
Cephalometric radiographic image	No charge	Once every 12 months
2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	Once every 12 months

Dental X-Rays		
Intraoral tomosynthesis - comprehensive series	No charge	Once every 36 months
Intraoral tomosynthesis - bitewing image	No charge	Once every 12 months
Intraoral tomosynthesis - periapical image	No charge	Once every 12 months
Intraoral tomosynthesis - comprehensive series image capture	No charge	Once every 36 months
Intraoral tomosynthesis - bitewing image capture	No charge	Once every 12 months
Intraoral tomosynthesis - periapical image capture	No charge	Once every 12 months
Prophylaxis (Cleaning)		
Prophylaxis (Cleaning) – Adult	No charge	Once every 6 months
Fluoride Treatment		
Topical application of fluoride varnish	No charge	Once every 6 months
Topical application of fluoride - excluding varnish	No charge	Once every 6 months

Supplemental Comprehensive Dental Services		
Restorative Services		
Amalgam - one surface, primary or permanent	No charge	Once every 24 months
Amalgam - two surfaces, primary or permanent	No charge	Once every 24 months
Amalgam - three surface, primary or permanent	No charge	Once every 24 months
Amalgam - four surfaces, primary or permanent	No charge	Once every 24 months
Resin-1 surface, anterior	No charge	Once every 24 months
Resin-2 surfaces, anterior	No charge	Once every 24 months
Resin-3 surfaces, anterior	No charge	Once every 24 months
Resin-4+ surfaces or anterior	No charge	Once every 24 months
Comp resin crown, anterior	No charge	Once every 24 months
Composite - 1 surf posterior	No charge	Once every 24 months
Composite - 2 surf posterior	No charge	Once every 24 months
Composite - 3 surf posterior	No charge	Once every 24 months
Resin-4+ surf, posterior	No charge	Once every 24 months
Inlay – Metallic, One Surface	$150	Once every 60 months
Inlay – Metallic, Two Surfaces	$150	Once every 60 months
Inlay – Metallic, Three or More Surfaces	$150	Once every 60 months
Onlay – Metallic, Two Surfaces	$150	Once every 60 months

Restorative Services		
Inlay – Porcelain/Ceramic, Two Surfaces	$150	Once every 60 months
Inlay – Porcelain/Ceramic, Three or More Surfaces	$150	Once every 60 months
Crown-resin-based composite (indirect)	$150	Once every 60 months
Crown-3/4 resin-based composite (indirect)	$150	Once every 60 months
Crown-resin with high noble metal	$150	Once every 60 months
Crown-resin with predominantly base metal	$150	Once every 60 months
Crown-resin with noble metal	$150	Once every 60 months
Crown-porcelain/ceramic substrate	$150	Once every 60 months
Crown-porcelain fused to high noble metal	$150	Once every 60 months
Crown-porcelain fused to predominantly base metal	$150	Once every 60 months
Crown-porcelain fused to noble metal	$150	Once every 60 months
Crown-porcelain fused to titanium/titanium alloys	$150	Once every 60 months
Crown-full cast high noble metal	$150	Once every 60 months

Restorative Services		
Crown-full cast predominantly base metal	$150	Once every 60 months
Crown-full cast noble metal	$150	Once every 60 months
Recement inlay, onlay or partial coverage restoration	No charge	Once every 6 months
Recement crown	No charge	Once every 6 months
Reattachment of tooth fragment	No charge	Once every 6 months
Prefabricated stainless steel crown-primary tooth	No charge	Once every 60 months
Prefabricated stainless steel crown-permanent	No charge	Once every 60 months
Pin retention-per tooth, in addition to restoration	No charge	Once every 60 months
Post and core in addition to crown, indirectly fabricated	$50	Once per 60 months
Each additional indirectly fabricated post, same tooth	$50	Once per 60 months
Prefabricated post and core in addition to crown	$50	Once per 60 months
Endodontic Services		
Therapeutic Pulpotomy	No charge	Once per lifetime
Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)	No charge	Once per lifetime

Endodontic Services		
Pulpal therapy (resorbable filling)- posterior, primary tooth, (excluding final restoration)	No charge	Once per lifetime
Root canal, anterior	No charge	Once per lifetime
Pulpal therapy (resorbable filling)- posterior, primary tooth, (excluding final restoration)	No charge	Once per lifetime
Root canal, anterior	$40	Once per lifetime
Retreatment of previous root canal therapy-anterior	No charge	Once per lifetime
Retreatment of previous root canal therapy-bicuspid	No charge	Once per lifetime
Retreatment of previous root canal therapy-molar	$40	Once per lifetime
Apicoectomy - anterior	$40	Once per lifetime
Apicoectomy - premolar (first root)	$40	Once per lifetime
Apicoectomy - molar (first root)	$40	Once per lifetime
Apicoectomy (each additional root)	$40	Once per lifetime
Retrograde filling - per root	$40	Once per lifetime

Endodontic Services		
Surgical exposure of root surface - anterior	$40	Once per lifetime
Surgical exposure of root surface - premolar	$40	Once per lifetime
Surgical exposure of root surface - molar	$40	Once per lifetime
Periodontic Services		
Gingivectomy or Gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$40	Once per 36 months
Gingival flap procedure - four or more teeth	$40	Once per 60 months
Osseous surgery - per quadrant	$150	Once per 60 months
Osseous surgery (including flap entry and closure)- one to three contiguous teeth or bounded teeth spaces per quadrant	$150	Once per 60 months
Periodontal scaling and root planing - four or more teeth per quadrant	No charge	Once per 36 months
Periodontal scaling and root planing - one to three teeth per quadrant	No charge	Once per 36 months

Periodontic Services		
Full mouth debridement to enable comprehensive evaluation and diagnosis	No charge	Once per 36 months
Periodontal maintenance procedures	No charge	Once per 36 months
Prosthodontic Removable Services		
Complete denture - maxillary	$150	Once per 60 months
Complete denture - mandibular	$150	Once per 60 months
Immediate denture - maxillary	$150	Once per 60 months
Immediate denture - mandibular	$150	Once per 60 months
Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	$150	Once per 60 months
Mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	$150	Once per 60 months
Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$150	Once per 60 months

Prosthodontic Removable Services		
Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$150	Once per 60 months
Removable unilateral partial denture - maxillary	$150	Once per 60 months
Removable unilateral partial denture - mandibular	$150	Once per 60 months
Removable unilateral partial denture-flexible base	$150	Once per 60 months
Removable unilateral partial denture-1 piece resin	$150	Once per 60 months
Adjust complete denture-maxillary	No charge	Two per 12 months
Adjust complete denture - mandibular	No charge	Two per 12 months
Adjust partial denture - maxillary	No charge	Two per 12 months
Adjust partial denture - mandibular	No charge	Two per 12 months
Repair broken complete denture base, mandibular	No charge	Once per 12 months
Repair broken complete denture base, maxillary	No charge	Once per 12 months

Prosthodontic Removable Services		
Replace missing or broken teeth -complete denture (each tooth)	No charge	Once per 12 months
Repair resin partial denture base, mandibular	No charge	Once per 12 months
Repair resin partial denture base, maxillary	No charge	Once per 12 months
Repair cast partial framework, mandibular	No charge	Once per 12 months
Repair cast partial framework, maxillary	No charge	Once per 12 months
Repair or replace broken retentive/clasping materials per tooth	No charge	Once per 12 months
Replace broken teeth - per tooth	No charge	Once per 12 months
Add tooth to existing partial denture	No charge	Once per 12 months
Add clasp to existing partial denture	No charge	Once per 12 months
Rebase complete maxillary denture	No charge	Once per 12 months
Rebase complete mandibular denture	No charge	Once per 12 months
Rebase maxillary partial denture	No charge	Once per 12 months

Prosthodontic Removable Services		
Rebase mandibulary partial denture	No charge	Once per 12 months
Rebase hybrid prosthesis	No charge	Once per 12 months
Reline complete maxillary denture (chairside)	No charge	Once per 12 months
Reline complete mandibular denture (chairside)	No charge	Once per 12 months
Reline maxillary partial denture (chairside)	No charge	Once per 12 months
Reline mandibular partial denture (chairside)	No charge	Once per 12 months
Reline complete maxillary denture (laboratory)	No charge	Once per 12 months
Reline complete mandibular denture (laboratory)	No charge	Once per 12 months
Reline maxillary partial denture (laboratory)	No charge	Once per 12 months
Reline mandibular partial denture (laboratory)	No charge	Once per 12 months
Overdenture - complete maxillary	$150	Once per 60 months
Overdenture - partial maxillary	$150	Once per 60 months
Overdenture - complete mandibular	$150	Once per 60 months

Prosthodontic Removable Services		
Overdenture - partial mandibular	$150	Once per 60 months
Prosthodontics Fixed Services		
Pontic - cast high noble metal	$150	Once per 60 months
Pontic-cast base metal	$150	Once per 60 months
Pontic - cast noble metal	$150	Once per 60 months
Pontic-porcelain fused-high noble	$150	Once per 60 months
Pontic-porcelain fused to base metal	$150	Once per 60 months
Pontic-porcelain fused-noble metal	$150	Once per 60 months
Pontic - porcelain/titanium and titanium alloys	$150	Once per 60 months
Pontic - resin with high noble metal	$150	Once per 60 months
Pontic-resin with base metal	$150	Once per 60 months
Pontic-resin with noble metal	$150	Once per 60 months
Retainer - cast metal fixed	$150	Once per 60 months
Onlay - cast high noble metal, two surfaces	$150	Once per 60 months
Crown - indirect resin based composite	$150	Once per 60 months
Crown - resin with high noble metal	$150	Once per 60 months

Prosthodontics Fixed Services		
Crown - resin with predominantly base metal	$150	Once per 60 months
Crown - resin with noble metal	$150	Once per 60 months
Retainer crown, porcelain/ ceramic	$150	Once per 60 months
Crown-porcelain fused high noble	$150	Once per 60 months
Crown-porcelain fused to base metal	$150	Once per 60 months
Crown-porcelain fused noble metal	$150	Once per 60 months
Retainer crown- porcelain fused to titanium and titanium alloys	$150	Once per 60 months
Crown-full cast high noble	$100	Once per 60 months
Crown - full cast base metal	$100	Once per 60 months
Crown - full cast noble metal	$100	Once per 60 months
Re-cement or re-bond fixed partial denture	No charge	Once per 24 months
Oral and Maxillofacial Surgery Services		
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No charge	Once per lifetime

Oral and Maxillofacial Surgery Services		
Surgical removal erupted tooth	No charge	Once per lifetime
Removal impacted tooth-soft	No charge	Once per lifetime
Removal of impacted tooth - partially bony	$100	Once per lifetime
Remove impact tooth-comp bony	$100	Once per lifetime
Removal of impacted tooth - completely bony, with unusual surgical complications	$100	Once per lifetime
Surgical remove residual tooth roots	$100	Once per lifetime
Oralantral fistula closure	$100	Once per lifetime
Surgical access of an unerupted tooth	$100	Once per lifetime
Mobilization of erupted or malpositioned tooth to aid eruption	$100	Once per lifetime
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No charge	Once per lifetime

Oral and Maxillofacial Surgery Services		
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No charge	Once per 12 months
Vestibuloplasty - ridge extension (second epitheliazation)	$100	Once per 60 months
Radical excision - lesion diameter up to 1.25cm	$100	Covered
Excision of benign lesion greater than 1.25 cm	$100	Covered
Excision of malignant tumor - lesion diameter up to 1.25 cm	$100	Covered
Excision of malignant tumor - lesion diameter greater than 1.25 cm	$100	Covered
Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$100	Covered
Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$100	Covered

Oral and Maxillofacial Surgery Services		
Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$100	Covered
Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$100	Covered
Removal of exostosis - per site	$100	Once per lifetime
Removal of torus mandibularis	$100	Covered
Incision and drainage of abscess - intraoral soft tissue	$100	Covered
Incision and drainage of abscess - extraoral soft tissue	$100	Covered
Buccal/labial frenectomy (frenulectomy)	$100	Three per lifetime
Lingual frenectomy (frenulectomy)	$100	Three per lifetime
Excision of hyperplastic tissue - per arch	$100	Twice per lifetime
Excision of pericoronal gingiva	$100	Once per 24 months
Surgical reduction of fibrous tuberosity	$100	Twice per lifetime

Adjunctive General Services		
Palliative treatment of dental pain - per visit	No charge	Twice per 12 months
Local anesthesia not in conjunction with operative or surgical procedure *Not billable separately from main service.	No charge	Covered
Regional block anesthesia*Not billable separately from main service.	No charge	Covered
Trigeminal division block anesthesia*Not billable separately from main service.	No charge	Covered
Local anesthesia *Not billable separately from main service.	No charge	Covered
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No charge	Covered

Adjunctive General Services		
Office visit for observation (during regularly scheduled hours)-no other services performed	No charge	Covered
Occlusal adjustment - limited	No charge	Covered
Occlusal adjustment - complete	No charge	Covered

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Eye Care	Vision Exams	$35 copayment for Medicare-covered eye exams.	
		$0 Copayment for one routine eye exam for eyewear.	You may receive one Eye Exam every year.
	Vision Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.	
		$0 copayment for Non-Medicare-covered eyewear (Routine) up to $200 annual maximum every year.	Includes contact lenses and eyeglasses.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care	Inpatient Mental Health	You pay per admission: • Days 1–5: $400 copayment each day. • Day 6 and beyond: $0 copayment each day.	Authorization is required.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care *(continued)*	Outpatient Mental Health	**In-Network** Mental Health Individual Sessions:$20 Copayment for each office session. Mental Health Group Sessions:$5 Copayment for each office session. $10 Copayment for telehealth services. **Out-of-Network** Mental Health Individual Sessions:$20 Copayment for each office session. Mental Health Group Sessions:$5 Copayment for each office session.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Mental Health Care *(continued)*	Outpatient Mental Health *(continued)*	**In-Network** Psychiatric Services Individual Sessions:$25 Copayment for each office session. Psychiatric Services Group Sessions:$5 Copayment for each office session. $10 Copayment for telehealth services. **Out-of-Network** Psychiatric Services Individual Sessions:$25 Copayment for each office session. Psychiatric Services Group Sessions:$5 Copayment for each office session.	Please call your current provider for telehealth services details.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Rehabili-tative or Skilled Nursing Care	Skilled Nursing Facility	You pay per admission: Days 1–20: $0 copayment per day. Days 21–100: $218 copayment per day. Days 101 and beyond: you pay all cost.	The plan covers up to 100 days each benefit period, a 3-day prior hospital stay is required. Authorization is required.
You need Outpatient Therapy	Physical Therapy	**In-Network** $35 copayment for each visit. **Out-of-Network** $35 copayment for each visit.	Authorization is required.

Medicare-covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need help getting to health services	Ambulance copayment	$215 for each one-way trip.	Authorization is only required for non-emergency services.
	Transporta-tion	$0 copayment. You may take up to 32 one-way trips for medical related purposes every year.	You may take a taxi, bus, subway, van or rideshare.
You need drugs to treat your illness or condition	Medicare Part B Drugs	20% coinsurance for Medicare Part B Prescription Drugs. Up to $35 for Medicare Part B Insulin Drugs.	Authorization may be required for certain drugs.

Medicare Part D

If you qualify for Low-Income subsidy (also called "Extra Help"), you may not pay the amounts listed in the table below for your Part D prescription drugs. The exact amount you pay may vary depending on the amount of Extra Help you receive.

Part D Premium	$58.80 per month.
Part D Deductible	Tier 1, 2, and 3 Drugs: Part D deductible is $0. Tier 4 and 5 Drugs: Part D deductible is $375. Members pay the full cost of their drugs until their $375 deductible is met, then the cost-shares are applied in the initial coverage stage.

Medicare Part D

Part D Deductible & Initial Coverage Stage

Tier: Tier Name	**Part D Deductible**	Initial Coverage Stage		
		Retail Pharmacy Cost share (30-day supply)*Ω	Retail Pharmacy Cost share (Up to 90-day supply)^†Ω	Mail Order Pharmacy Cost share (Up to 90-day supply)†Ω
Tier 1: Preferred Generic Drugs	$0	$0 Copayment	$0 Copayment	$0 Copayment
Tier 2: Generic Drugs		$10 Copayment	$30 Copayment	$20 Copayment
Tier 3: Preferred Brand Drugs		$47 Copayment	$141 Copayment	$94 Copayment
Tier 4: Non-preferred Drugs	$375	$100 Copayment	$300 Copayment	$200 Copayment
Tier 5: Specialty Tier Drugs		28% Coinsurance	28% Coinsurance	28% Coinsurance

*One-month supply for Standard retail (in-network), Long-term care (31-day), and Out-of-network cost share.
^60-Day supply is also available for Standard retail (in-network).
†NDS – Non-Extended Days Supply. Certain Specialty drugs will be limited up to a 30-day supply per fill.

Medicare Part D

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.

Once your total drug costs have reached $2,100, you will move to the next stage (the Catastrophic stage).

Catastrophic Coverage Stage

Once your out-of-pocket costs reach a total of $2,100, you stay in this payment stage until the end of the calendar year.

Catastrophic Coverage	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Other Covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Medical Equipment and Supplies	Diabetic Supplies	$0 copayment for Medicare-Covered Diabetic Supplies.	Diabetic Test Strips and Blood Glucose Meters are limited to specific manufacturers: Abbott Diabetes Care and Ascensia Diabetes Care.
	Durable Medical Equipment (like wheelchairs or oxygen)	$0 copay for Freestyle Libre Continuous Glucose Monitors and supplies are available at participating pharmacies. 20% coinsurance for Medicare-covered Durable Medical Equipment (DME).	Continuous Glucose Monitors are limited to specific manufacturers: Freestyle Libre. Authorization is required. Authorization is required for certain items.

Other Covered Benefits			
Health Need or Problem	**Covered Benefit**	**Your Cost Share**	**What You Should Know**
You need Medical Equipment and Supplies (continued)	Medical Supplies	20% coinsurance for Medical Supplies.	Authorization is required.
	Prosthetics (artificial limbs or braces)	20% coinsurance for Prosthetic Devices.	Authorization is required.
You need Rehabilitation Services	Physical Therapy, Occupational Therapy, Speech Language Therapy	**In-Network** $35 copayment for each visit. **Out-of-Network** $35 copayment for each visit.	Authorization is required.
	Cardiac Rehabilitation	$10 copayment for Cardiac Rehabilitation Services.	Authorization is required.
	Pulmonary Rehabilitation	$15 copayment for Pulmonary Rehabilitation Services.	Authorization is required.

More benefits with your plan	
Expanded Acupuncture Services	$0 copayment per visit. You may receive up to 20 visits per year for the following services: • Acupuncture • Cupping/Moxa • Acupressure • Tui Na • Gua Sha • Reflexology • Infrared Therapy
Brain Games with BrainHQ®	There is no copayment or coinsurance for BrainHQ®. Members will have access to an online memory fitness program to improve brain function through games, puzzles and other fun exercises.
Flex Card	There is no coinsurance or copayment for Flex Card. You will receive a $450 allowance to use in 2026 on out-of-pocket costs for dental, vision, hearing, and/or fitness services. Any unused benefit dollars will expire at the end of the calendar year or if you disenroll from the plan.

More benefits with your plan	
OTC	You may purchase up to $140 every quarter of eligible OTC items on an OTC card provided by Elderplan.
OTC + Grocery + Meals	For eligible members (with certain chronic conditions) the Special Supplemental Benefits for the Chronically Ill combines with the OTC benefit to cover certain grocery items and meals as a part of the quarterly OTC allowance.
Routine Podiatry Services	**In-Network** $35 copayment per visit. You may receive up to 10 visits per year. **Out-of-Network** $35 copayment per visit. You may receive up to 10 visits per year.

More benefits with your plan	
Silver&Fit® Fitness Program	Members have access to the Silver&Fit® Healthy Aging and Exercise program at no cost. Under this program, members can access no-cost participating fitness centers. In addition, members can choose 1 (one) home fitness kit per benefit year at no cost. Members can also access other Silver&Fit program features including thousands of on-demand workout videos, virtual events through the Well-Being club, and specialized coaching sessions. The Silver&Fit toll-free number is 1-877-427-4788 (TTY 711) Monday through Friday, 8 am to 9 pm.
Teladoc®	At $0 cost share, Teladoc® connects you with board-certified doctors 24 hours a day, 7 days a week for video or phone chat using your smartphone, tablet or computer. These doctors can help diagnose, treat and even write prescriptions for a variety of non-emergency conditions.

More benefits with your plan	
Travel Assistance	Get help 24/7 when you travel more than 100 miles away from home or to another country. This program connects you to doctors, hospitals, pharmacies, and other services all over the world, so you're never without access to care.
Worldwide Emergency/ Emergency Transportation / Urgent Coverage	$0 copayment for Worldwide Emergency Coverage / Emergency Transportation / Urgent Coverage. The maximum benefit coverage amount is $50,000. There is no coinsurance or copayment for Worldwide Emergency Travel Assistance services arranged by our worldwide emergency travel assistance provider.

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, 46th Floor
New York NY 10041

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

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

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

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services
45 CFR 92.11

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

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

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

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

Arabic

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services
45 CFR 92.11

Urdu

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

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

Yiddish

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

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-353-3765**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.elderplan.org** or call **1-800-353-3765** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on **January 1, 2027**.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- ☐ Your medical and prescription coverage were reviewed against your current insurance coverage. You will become a member of Elderplan upon enrollment verification and no longer have coverage with your current plan.

elderplan homefirst®

a participating agency of MJHS Health System

For more information, call us toll-free

1-800-353-3765

8 a.m.–8 p.m., 7 days a week.

TTY/TDD users should call

711

Visit our website

Elderplan.org

Elderplan is an HMO plan with Medicare and Medicaid contracts. 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 if not otherwise paid for under Medicaid.