

2026



Leading the way to great care.™



Summary of Benefits

Elderplan Flex (HMO-POS)

January 1, 2026 to December 31, 2026

Summary of Benefits – **Elderplan Flex (HMO-POS) 2026**

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



Summary of Benefits

for **Elderplan Flex (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 Flex (HMO-POS)

Plan Overview

A health plan designed to give Medicare beneficiaries the flexibility to choose the benefits and doctors they want.

In addition to medical, hospital, and prescription drug coverage, you can choose either a quarterly OTC benefit or transportation to and from medical appointments. You'll 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.

Contents














Section I: Introduction to Summary of Benefits7

- Elderplan Contact Information
- Who Can Join?
- Useful Information About Medicare
- Information About Elderplan Flex

Section II: Summary of Benefits14

- Monthly Premium, Deductible, And Maximum Out-Of-Pocket Costs
- Medicare-Covered Benefits
- Prescription Drug Benefits
- Other Covered Benefits

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 Preventive and Comprehensive Dental | |
|  | Routine Hearing | |
|  | Routine Vision | |
|  | Silver&Fit® Fitness Program | |
|  | 24/7 Access to Care with Teladoc® | |
|  | Flex Card‡ | \$450 every year |
|  | Specialist Care | \$35 |
|  | Routine Podiatry | |

Summary of Benefits – **Elderplan Flex (HMO-POS) 2026**

Choose one of our **Select Extras**:



- Over-the-Counter (OTC) benefit

or



- Transportation benefit



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

\$140 every quarter
or
48 one-way trips



Use your Transportation benefit to go to approved locations such as doctor appointments.

*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 copays for certain services and out-of-pocket dental, vision, hearing, and/or fitness expenses.

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 Flex (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 Flex 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 Flex 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 Flex (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

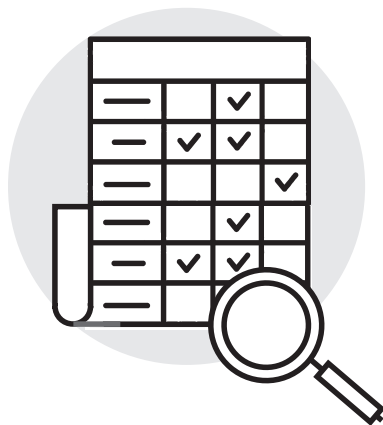
Useful Information About Medicare

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 Flex (HMO-POS)).
- You can compare Elderplan Flex 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.

Tips for Comparing your Medicare Choices

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



Summary of Benefits – Elderplan Flex (HMO-POS) 2026

- 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 Flex

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 Flex (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.

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

- 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 Flex.

| Elderplan Flex (HMO-POS) | | |
|----------------------------------|--|--|
| Monthly Premium (Part D Premium) | \$0 | 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. | <p>Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay cost-sharing for your Part D prescription drugs.</p> |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---------------------------|----------------------------------|--|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need hospital care | Inpatient Hospital Services | <p>You pay per admission:</p> <ul style="list-style-type: none"> • 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. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|--|---|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You want to see a doctor <i>(continued)</i> | 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. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|-----------------|---|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You want to see a doctor <i>(continued)</i> | 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. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---|---------------------------------------|-----------------|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You want to see a doctor <i>(continued)</i> | Preventive Care <i>(continued)</i> | | <ul style="list-style-type: none"> • Abdominal aortic aneurysm screenings • Alcohol misuse screenings & counseling • Bone mass measurements • Cardiovascular disease screenings • Cardiovascular disease (behavioral therapy) • Cervical & vaginal cancer screenings • Colorectal cancer screenings <ul style="list-style-type: none"> - Blood-based biomarker tests - Colonoscopies - Computed tomography (CT) colonography - Fecal occult blood tests - Flexible sigmoidoscopies - 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---|---------------------------------------|-----------------|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You want to see a doctor <i>(continued)</i> | Preventive Care <i>(continued)</i> | | <ul style="list-style-type: none"> • Hepatitis B virus (HBV) infection screenings • 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 • Sexually transmitted infections screenings & counseling • Shots: <ul style="list-style-type: none"> - COVID-19 vaccines - Flu shots - Hepatitis B shots - Pneumococcal shots • Yearly “Wellness” Visit |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---------------------------|-----------------|--|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You Need Emergency Care | Emergency Care | \$115 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 in-network telehealth services details. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| 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. | |
| | Diagnostic Services/ Labs/Imaging • Outpatient X-rays | \$20 copayment for each service. | |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---|--|-----------------------------------|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need medical tests <i>(continued)</i> | Diagnostic Services/ Labs/Imaging <ul style="list-style-type: none">• 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). |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| 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 year. | |
| | Hearing Aids | Up to \$1,500 maximum benefit every year for both ears combined (\$750 will be available per ear). \$0 copayment for Fitting/Evaluation for Hearing Aid every year. | Authorization is required for hearing aid(s) by a Physician or Specialist. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---------------------------|----------------------------|--|----------------------|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Dental Care | Preventive Dental Services | \$0 for coverage of Supplemental Diagnostic & Preventive Dental Services are limited to selected service codes from the categories below In-Network and Out-of-Network combined. | |

Summary of Benefits – **Elderplan Flex (HMO-POS) 2026**

| Medicare-covered Benefits | | | |
|---|-------------------------------|---|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Dental Care <i>(continued)</i> | Comprehensive Dental Services | <p>You pay \$0 copayment for Supplemental Comprehensive Dental Services up to \$2,500 in-network and out-of-network combined annual maximum benefit. You pay all costs beyond benefit maximum.</p> <p>Coverage of Supplemental Comprehensive Dental Services are limited to selected service codes from the categories below in & out-of-network.</p> | <p>Supplemental Comprehensive Dental Services. Benefit frequency may be limited per American Dental Association guidelines.</p> |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|---|---|----------------------|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Dental Care <i>(continued)</i> | Comprehensive Dental Services <i>(continued)</i> | 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

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 | No charge | Once every 60 months |
| Inlay – Metallic, Two Surfaces | No charge | Once every 60 months |
| Inlay – Metallic, Three or More Surfaces | No charge | Once every 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Restorative Services

| | | |
|---|-----------|----------------------|
| Onlay – Metallic, Two Surfaces | No charge | Once every 60 months |
| Inlay – Porcelain/Ceramic, Two Surfaces | No charge | Once every 60 months |
| Inlay – Porcelain/Ceramic, Three or More Surfaces | No charge | Once every 60 months |
| Crown-resin-based composite (indirect) | No charge | Once every 60 months |
| Crown-3/4 resin-based composite (indirect) | No charge | Once every 60 months |
| Crown-resin with high noble metal | No charge | Once every 60 months |
| Crown-resin with predominantly base metal | No charge | Once every 60 months |
| Crown-resin with noble metal | No charge | Once every 60 months |
| Crown-porcelain/ceramic substrate | No charge | Once every 60 months |
| Crown-porcelain fused to high noble metal | No charge | Once every 60 months |
| Crown-porcelain fused to predominantly base metal | No charge | Once every 60 months |
| Crown-porcelain fused to noble metal | No charge | Once every 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Restorative Services | | |
|---|-----------|----------------------|
| Crown-porcelain fused to titanium/titanium alloys | No charge | Once every 60 months |
| Crown-full cast high noble metal | No charge | Once every 60 months |
| Crown-full cast predominantly base metal | No charge | Once every 60 months |
| Crown-full cast noble metal | No charge | 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 | No charge | Once per 60 months |
| Each additional indirectly fabricated post, same tooth | No charge | Once per 60 months |
| Prefabricated post and core in addition to crown | No charge | Once per 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Endodontic Services | | |
|--|-----------|-------------------|
| Therapeutic Pulpotomy | No charge | Once per lifetime |
| Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration) | No charge | Once per lifetime |
| Pulpal therapy (resorbable filling)- posterior, primary tooth, (excluding final restoration) | No charge | Once per lifetime |
| Root canal, anterior | No charge | Once per lifetime |
| Root canal, bicuspid | No charge | Once per lifetime |
| Root canal, molar | No charge | 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 | No charge | Once per lifetime |
| Apicoectomy - anterior | No charge | Once per lifetime |
| Apicoectomy - premolar (first root) | No charge | Once per lifetime |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Endodontic Services

| | | |
|--|-----------|-------------------|
| Apicoectomy - molar (first root) | No charge | Once per lifetime |
| Apicoectomy (each additional root) | No charge | Once per lifetime |
| Retrograde filling - per root | No charge | Once per lifetime |
| Surgical exposure of root surface - anterior | No charge | Once per lifetime |
| Surgical exposure of root surface - premolar | No charge | Once per lifetime |
| Surgical exposure of root surface - molar | No charge | Once per lifetime |

Periodontic Services

| | | |
|--|-----------|--------------------|
| Gingivectomy or Gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | No charge | Once per 36 months |
| Gingival flap procedure - four or more teeth | No charge | Once per 60 months |
| Osseous surgery - per quadrant | No charge | Once per 60 months |
| Osseous surgery (including flap entry and closure)- one to three contiguous teeth or bounded teeth spaces per quadrant | No charge | Once per 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Periodontic Services

| | | |
|---|-----------|--------------------|
| 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 |
| 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 | No charge | Once per 60 months |
| Complete denture - mandibular | No charge | Once per 60 months |
| Immediate denture - maxillary | No charge | Once per 60 months |
| Immediate denture - mandibular | No charge | Once per 60 months |
| Maxillary partial denture-resin base (including any conventional clasps, rests and teeth) | No charge | Once per 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Prosthodontics, Removable

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

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Prosthodontics, Removable

| | | |
|---|-----------|--------------------|
| 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 |
| 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Prosthodontics, Removable | | |
|--|-----------|--------------------|
| 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 |
| Rebase mandibular 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Prosthodontics, Removable

| | | |
|---|-----------|--------------------|
| 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 | No charge | Once per 60 months |
| Overdenture - partial maxillary | No charge | Once per 60 months |
| Overdenture - complete mandibular | No charge | Once per 60 months |
| Overdenture - partial mandibular | No charge | Once per 60 months |

Prosthodontics Fixed Services

| | | |
|--------------------------------------|-----------|--------------------|
| Pontic - cast high noble metal | No charge | Once per 60 months |
| Pontic-cast base metal | No charge | Once per 60 months |
| Pontic - cast noble metal | No charge | Once per 60 months |
| Pontic-porcelain fused - high noble | No charge | Once per 60 months |
| Pontic-porcelain fused to base metal | No charge | Once per 60 months |
| Pontic-porcelain fused - noble metal | No charge | Once per 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Prosthodontics Fixed Services | | |
|---|-----------|--------------------|
| Pontic - porcelain/titanium and titanium alloys | No charge | Once per 60 months |
| Pontic - resin with high noble metal | No charge | Once per 60 months |
| Pontic-resin with base metal | No charge | Once per 60 months |
| Pontic-resin with noble metal | No charge | Once per 60 months |
| Retainer - cast metal for resin bonded fixed prosthesis | No charge | Once per 60 months |
| Onlay - cast high noble metal, two surfaces | No charge | Once per 60 months |
| Crown - indirect resin based composite | No charge | Once per 60 months |
| Crown - resin with high noble metal | No charge | Once per 60 months |
| Crown - resin with predominantly base metal | No charge | Once per 60 months |
| Crown - resin with noble metal | No charge | Once per 60 months |
| Retainer crown, porcelain/ceramic | No charge | Once per 60 months |
| Crown-porcelain fused high noble | No charge | Once per 60 months |
| Crown-porcelain fused to base metal | No charge | Once per 60 months |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Prosthodontics Fixed Services

| | | |
|---|-----------|--------------------|
| Crown-porcelain fused noble metal | No charge | Once per 60 months |
| Retainer Crown- Porcelain fused to titanium and titanium alloys | No charge | Once per 60 months |
| Crown-full cast high noble | No charge | Once per 60 months |
| Crown - full cast base metal | No charge | Once per 60 months |
| Crown - full cast noble metal | No charge | 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 |
| Surgical removal erupted tooth | No charge | Once per lifetime |
| Removal impacted tooth-soft | No charge | Once per lifetime |
| Removal of impacted tooth - partially bony | No charge | Once per lifetime |
| Remove impact tooth-comp bony | No charge | Once per lifetime |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Oral and Maxillofacial Surgery Services | | |
|--|-----------|--------------------|
| Removal of impacted tooth - completely bony, with unusual surgical complications | No charge | Once per lifetime |
| Surgical remove residual tooth roots | No charge | Once per lifetime |
| Oral-antral fistula closure | No charge | Once per lifetime |
| Surgical access of an unerupted tooth | No charge | Once per lifetime |
| Mobilization of erupted or malpositioned tooth to aid eruption | No charge | Once per lifetime |
| Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | No charge | Once per lifetime |
| 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 epithelialization) | No charge | Once per 60 months |
| Radical excision - lesion diameter up to 1.25cm | No charge | Covered |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Oral and Maxillofacial Surgery Services

| | | |
|---|-----------|---------|
| Excision of benign lesion greater than 1.25 cm | No charge | Covered |
| Excision of malignant tumor - lesion diameter up to 1.25 cm | No charge | Covered |
| Excision of malignant tumor - lesion diameter greater than 1.25 cm | No charge | Covered |
| Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | No charge | Covered |
| Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | No charge | Covered |
| Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | No charge | Covered |
| Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | No charge | Covered |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Oral and Maxillofacial Surgery Services

| | | |
|--|-----------|--------------------|
| Removal of exostosis - per site | No charge | Once per lifetime |
| Removal of torus mandibularis | No charge | Covered |
| Incision and drainage of abscess - intraoral soft tissue | No charge | Covered |
| Incision and drainage of abscess - extraoral soft tissue | No charge | Covered |
| Buccal/labial frenectomy (frenulectomy) | No charge | Three per lifetime |
| Lingual frenectomy (frenulectomy) | No charge | Three per lifetime |
| Excision of hyperplastic tissue - per arch | No charge | Twice per lifetime |
| Excision of pericoronal gingiva | No charge | Once per 24 months |
| Surgical reduction of fibrous tuberosity | No charge | 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

Adjunctive General Services

| | | |
|---|-----------|---------|
| 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 |
| 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 |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|---------------------------|-----------------|---|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Eye Care | Vision Exams | \$25 copayment for Medicare-covered eye exams. | You may receive one Eye Exam every year. |
| | | \$0 Copayment for one routine eye exam for eyewear. | |
| | Vision Eyewear | \$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. | Includes contact lenses and eyeglasses. |
| | | \$0 copayment for Non-Medicare-covered eyewear (Routine) up to \$500 annual maximum every year. | |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|-----------------------------|--------------------------|--|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Mental Health Care | Inpatient Mental Health | <p>You pay per admission:</p> <ul style="list-style-type: none"> • Days 1–5: \$375 copayment each day. • Day 6 and beyond: \$0 copayment each day. | Authorization is required. |
| | Outpatient Mental Health | <p>In-Network</p> <p>Mental Health Individual Sessions: \$20 Copayment for each office session. \$10 Copayment for telehealth services.</p> <p>Mental Health Group Sessions: \$5 Copayment for each office session. \$10 Copayment for telehealth services.</p> | Please call your current provider for telehealth services details. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|--|---|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Mental Health Care <i>(continued)</i> | Outpatient Mental Health <i>(continued)</i> | Out-of-Network Mental Health Individual Sessions: \$20 Copayment for each office session. Mental Health Group Sessions: \$5 Copayment for each office session. In-Network Psychiatric Services Individual Sessions: \$25 Copayment for each office session. \$10 Copayment for telehealth services. Psychiatric Services Group Sessions: \$5 Copayment for each office session. \$10 Copayment for telehealth services. | Please call your current provider for In-Network telehealth services details. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|--|---|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Mental Health Care <i>(continued)</i> | Outpatient Mental Health <i>(continued)</i> | Out-of-Network Psychiatric Services Individual Sessions: \$25 Copayment for each office session. Psychiatric Services Group Sessions: \$5 Copayment for each office session. | |
| You need Rehabilitative or Skilled Nursing Care | Skilled Nursing Facility | You pay per admission: Days 1–20: \$0 copayment per day Days 21–100: \$196 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. |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| Medicare-covered Benefits | | | |
|--|---------------------|--|---|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| You need Outpatient Therapy | Physical Therapy | In-Network \$35 copayment for each visit. Out-of-Network \$35 copayment for each visit. | Authorization is required. |
| | Ambulance copayment | \$215 for each one-way trip. | Authorization is only required for non-emergency services. |
| You need help getting to health services | Transportation | \$0 copayment. You may take up to 48 one-way trips for medical related purposes every year. | You may take a taxi, bus, subway, van or rideshare. To use this benefit, you must choose it as your Elderplan Flex Select Extras benefit. |

Summary of Benefits – **Elderplan Flex (HMO-POS) 2026**

| Medicare-covered Benefits | | | |
|---|-----------------------|--|--|
| Health Need or Problem | Covered Benefit | Your Cost Share | What You Should Know |
| 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 | \$0 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. |



Summary of Benefits – Elderplan Flex (HMO-POS) 2026

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.

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

Medicare Part D

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. |
|------------------------------|--|

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| 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) | <p>\$0 copay for Freestyle Libre Continuous Glucose Monitors and supplies are available at participating pharmacies.</p> <p>20% coinsurance for Medicare-covered Durable Medical Equipment (DME).</p> | <p>Continuous Glucose Monitors are limited to specific manufacturers: Freestyle Libre. Authorization is required.</p> <p>Authorization is required for certain items.</p> |

Summary of Benefits – Elderplan Flex (HMO-POS) 2026

| 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 per visit. Out-of-Network \$35 copayment per 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 | <p>\$0 copayment per visit. You may receive up to 20 visits per year for the following services:</p> <ul style="list-style-type: none">• Acupuncture• Cupping/Moxa• Acupressure• Tui Na• Gua Sha• Reflexology• Infrared Therapy |
| Brain Games with BrainHQ® | <p>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.</p> |

| More benefits with your plan | |
|------------------------------|---|
| 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 emergency care, outpatient diagnostic tests and therapeutic services, outpatient rehabilitation services, outpatient mental health services, provider specialist services, podiatry services, urgent care, 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. |
| OTC | You may purchase up to \$140 every quarter of eligible OTC items on an OTC card provided by Elderplan. To use this benefit, you must choose it as your Elderplan Flex Select Extras benefit. |

| More benefits with your plan | |
|------------------------------|--|
| 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. To use this benefit, you must choose OTC as your Elderplan Flex Select Extras benefit. |
| Routine Podiatry Services | In-Network \$35 copayment per visit. You may receive up to 12 visits per year. |
| | Out-of-Network \$35 copayment per visit. You may receive up to 12 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.

| More benefits with your plan | |
|------------------------------|---|
| 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. |
| 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. |

| More benefits with your plan | |
|---|---|
| Worldwide Emergency / Emergency Transportation / Urgent Coverage | <p>\$0 copayment for Worldwide Emergency Coverage / Emergency Transportation / Urgent Coverage. The maximum benefit coverage amount is \$50,000.</p> <p>There is no coinsurance or copayment for Worldwide Emergency Travel Assistance services arranged by our worldwide emergency travel assistance provider.</p> |



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- 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

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Arabic

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

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

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

Haitian Creole: Elderplan, Inc. konfòme l avèk lwa Federal sou dwa sivil ki aplikab yo epi li pa fè diskriminasyon sou baz ras, koulè, orijin 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。

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

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

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

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

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

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

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

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

Yiddish

Elderplan, Inc. פאָלגט די אָנווענדלעכע פעדעראלע ציווילע רעכט געזעצן און דיסקרימינירט נישט אויף דער באַזע פון ראַסע, קאָליר, נאַציאָנאַלער אָפּשטאַם, עלטער, דיסאַביליטי, אָדער געשלעכט. ופּמערקזאַמקייט: אויב איר רעדט אַ נישט-ענגלישע שפּראַך אָדער דאַרפֿט הילף מיט איבערזעצונג, זענען שפּראַך הילף באַדינונגען און פּאַסיק הילפּסמיטלען בנימצא פֿאַר אַיך אָן קיין אָפּצאָל. אויב איר דאַרפֿט 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.

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.